School of Nursing and Midwifery Studies
with
The Rotunda Hospital and Our Lady of Lourdes, Drogheda

Diploma in Midwifery
(Direct Entry)

Midwife Registration Education Programme
A Pilot Programme

Final Report of the Evaluation

August 2003

The University of Dublin Trinity College
Diploma in Midwifery
(Direct Entry)

A Pilot Programme

Midwife Registration Education Programme

Final Report of the Evaluation

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Direct Entry to Midwifery Committee

Membership

University of Dublin Trinity College:
Dr Cecily Begley  Director, School of Nursing and Midwifery Studies, Faculty of Health Sciences
Ms Margaret Carroll  Course Co-ordinator, Direct entry to Midwifery Programme
Ms Maebh Barry   Joint Course Co-ordinator (from 1st August 2002)
Mr Michael Hanna  Administrative Officer, Faculty of Health Sciences (until December 2001)
Mr Frank O’Rourke  Administrative Officer, School of Nursing and Midwifery Studies, Faculty of Health Sciences (from January 2002)

Our Lady of Lourdes Hospital, Louth/Meath Hospital Group, NEHB, Drogheda
Ms Mary Duff  Director of Nursing and Midwifery Services
Ms Pauline Treanor  Nurse Manager Women and Children’s Services (until April 2001)
Ms Colette McCann  Nurse Manager Women and Children’s Services (from April 2001)
Ms Patricia Larkin  Principal Midwifery Tutor
Ms Jean McMahon  Principal Midwifery Tutor (halftime from February 2002)
Mr Declan Collins  General Manager (until 2002)
Mr David Gaskin  Group General Manager (from 2002)

Rotunda Hospital
Miss Mary Kelly  Matron (until April 2001)
Ms Pauline Treanor  Director of Midwifery/Nursing (from April 2001)
Ms Anna Monaghan  Principal Midwifery Tutor (until September 2002)
Ms Deirdre Daly  Principal Midwifery Tutor (from 2nd September 2002)
Dr Peter McKenna  Master (until 31st December 2001)
Dr Michael Geary  Master (from 1st January 2002)
Mr Noel Nelson  General Manager/Secretary (until July 2002)
Mr Fintan Fagan  General Manager/Secretary (from July 2002)

An Bord Altranais
Ms Yvonne O’Shea  Chief Education Officer (until 21st September 2000 and appointment of Education Officer – Midwifery)
Ms Ursula Byrne  Education Officer – Midwifery (from 21st September 2000)

Midwifery Tutors Group
Ms Anna Monaghan  Chairperson (until September 2002)
Ms Norah Mansell-Quirke  Chairperson (from September 2002)

Department of Health and Children
Ms Mary Brosnan  Midwifery Adviser – Nursing Policy Division (until December 2001)
Ms Patricia Larkin  Midwifery Adviser – Nursing Policy Division (from January 2002)

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Ms Jill Atkinson  Midwife and Preceptor, Our Lady of Lourdes (until December 2001)
Ms Maria O’Shea  Midwife and Preceptor, Our Lady of Lourdes (from January 2002 until September 2002)
Ms Aoife O’Connor  Midwife and Preceptor, Our Lady of Lourdes (from September 2002)

Midwifery Students
Ms Deirdra Richardson
Chapter One

Introduction

This is the final report of the evaluation of the Diploma in Midwifery (Direct Entry). All stakeholders involved directly and indirectly in the programme – ‘direct entry’ midwifery students, PGDip midwifery students, midwives, midwife managers and teachers, obstetricians, paediatricians – participated in its evaluation. They have all stated that, overall, this project has been an overwhelming success, much more so than could ever have been imagined at the outset. All would qualify this by highlighting areas that need to be addressed for future developments but again would state that the success is evident in the product produced, the calibre of midwife. Immersion of midwifery students in practice from the outset and the support to facilitate this, provided in the form of supernumerary preceptorship, have been identified by the majority as key strengths. Another key finding was the overwhelming view that future programmes should be lengthened to four years and in doing so many respondents stated that the increase in time would easily address most of the shortcomings identified. It was also recommended that it be delivered at degree level, a shift that will not have a major impact as the pilot programme was perceived to be delivered for the most part at that level and depth. The process by which these main findings emerged will now be described.

1.1 Aims and objectives of the evaluation

The aim of the evaluation is to describe the development, delivery and ‘effectiveness in practice’ (Simons, 1998) of a pilot programme of direct entry into midwifery in Ireland and to determine the characteristics and the issues that are essential to the effectiveness of the programme, and the issues that need to be reconsidered. The specific objectives are to:

- describe the structure, process and outcomes of the development of the curriculum;
- describe the structure, process and outcomes of the delivery of the curriculum;
- explore in particular a number of aspects of the curriculum: the ‘supernumerary’ preceptorship period; sourcing, auditing and evaluation of practice placements; recruitment, attrition and retention; and the funding and cost of the programme;
- identify the strengths and weaknesses of the programme;
- identify aspects of the pilot programme that need to be reconsidered.
1.2 Overview of the structure and content of this report

Chapter one specifies the aim and outcomes of the interim evaluation. A synopsis of the background to the programme is provided in Chapter Two, while Chapter Three sets the context of Direct Entry to Midwifery from an international perspective. The design of the final evaluation is presented in Chapter Four. Chapter Five discusses the preparation for and evaluation of the development of the pilot programme. The next four Chapters are concerned with the delivery of the programme; Chapter Six details the evaluation of the delivery of the curriculum; the structure and evaluation of the supernumerary perceptorship period in year one is detailed in Chapter Seven; Chapter Eight details the sourcing and evaluation of external placements in particular; and issues about recruitment, attrition and retention are examined in Chapter Nine. Chapter Ten attempts to present the funding and costings for the programme. The final chapter, Chapter Eleven, presents a number of recommendations for consideration in the development of future programmes.
Chapter Two

Background to the programme

2.1 Introduction

The three-year pilot Midwife Registration Education Programme (Direct Entry) offered a new and challenging programme of midwifery education which, on completion, lead to registration as a midwife with An Bord Altranais and the award of a Diploma in Midwifery from the University of Dublin, Trinity College. The School of Nursing and Midwifery Studies, University of Dublin, Trinity College and its two linked maternity hospitals – The Rotunda Hospital, Dublin and Our Lady of Lourdes Louth/Meath Hospital Group, North Eastern Health Board (NEHB), Drogheda, delivered the pilot programme jointly.

The programme provided students without prior nursing professional qualifications the opportunity to register as a midwife. The pilot programme, commencing on the 1st June 2000, was the only programme delivered until the outcome of the evaluation is known.

2.2 Historical background to midwifery and midwifery education in Ireland

Direct entry into midwifery is not a new concept. During the late eighteenth century, women entered the Rotunda Hospital to train as midwives (An Bord Altranais 1994). Other lying-in hospitals provided training in the nineteenth century and, in 1918, the Midwives Act regulated the profession for the first time in Ireland. This act also provided for the training of nurses as midwives allowing for a period of training that was half that for any other woman (3 months for nurses versus 6 months for a direct entrant). Direct entry into the midwifery profession continued until 1959 when the last midwife to qualify from a direct entry programme in Ireland registered. It would appear that direct entry midwives were at a disadvantage as childbirth moved from the home into institutions. The dual-qualified midwife (nurse and midwife) was seen as more flexible as she could practise as a nurse as well as a midwife. The direct entry midwife was also denied the opportunity for promotion.
2.3 Midwifery education in Ireland since 1980

In Ireland, entry to the midwifery profession has necessitated initial registration as a registered general nurse followed by a two year midwifery education programme leading to registration as a midwife. Until 1995, midwives were awarded a certificate (and registration) from An Bord Altranais on successful completion of the educational programme. Gradually from 1995 – 1999 links were formed between the maternity hospitals and schools of midwifery responsible for the education of midwives and third level institutions in order to provide academic recognition for these programmes. Since October 2001 and the abolition of the state Midwifery Registration Examination, the successful completion of the totality of the programme is determined by the school of midwifery and the linked third level institution. Midwives are then awarded a Higher or Postgraduate Diploma in Midwifery and are eligible to registration in the Midwives’ Division of the Nurses Register. Access to further and higher education varies depending on the academic award granted. However, the competency level for midwifery practice and therefore ‘fitness for practice’, at the point of registration, must meet EU Directives and An Bord Altranais standards and requirements.

2.4 A pilot programme of direct entry midwifery

Following the deferral of a nurses’ and midwives’ strike in February 1997, a Commission on Nursing was established to “examine and report on the role of nurses (and midwives) in the health service” and “to provide a secure basis for the further professional development of nursing (and midwifery) in the context of anticipated changes in health services, their organisation and delivery” (Carroll 1998, pg 25). Following extensive consultation and request for submissions from interested parties, the Commission, in its final report ‘A Blueprint for the Future’, recognised the profession of midwifery as separate and distinct from the nursing profession. The final report made the following recommendations:

- Legislative changes that establish the separateness and distinctiveness of the midwifery profession should be introduced;
- The establishment of a Statutory Midwives’ Committee within An Bord Altranais responsible for issues relating to the scope of midwifery practice;
- Review of the theoretical content of the midwifery education programme for registered general nurses;
- The piloting of a Direct Entry to Midwifery education programme.
3.1 Introduction

This chapter aims to provide an overview of the status of direct entry to the profession of midwifery from an international perspective. A preliminary review of the literature in relation to the evaluation of direct entry to midwifery programmes has been undertaken and is presented here. To conclude, the strengths and weakness of direct entry route as identified is presented.

3.2 International perspective

As stated in Chapter Two, the last direct entry midwife to register in Ireland did so in 1959. In Europe as a whole, direct entry to the profession is a route in 7 countries with programmes varying in length from 3 to 4 years (Advisory Committee on the Training of Midwives 1991). The European Directives stipulate the minimum length of programmes. In our closest neighbour, the United Kingdom, similar trends to those seen in Ireland with regard to the demise of direct entry to the profession was observed and Radford and Thompson (1994) noted that by 1939 only 8.1% of candidates taking the midwifery state examination were non-nurses. By 1949 only 4% of midwifery students were not nurses and by 1983 the figure was 0.6%. By 1985 only one school of midwifery with a direct entry programme remained with a student intake of 8. However almost ten years later when Kent, MacKeith and Maggs (1994) published their evaluation of the implementation of direct entry midwifery (referred to as pre-registration midwifery education) there were 32 programmes running in 29 sites. In contrast, in the Netherlands, direct entry to midwifery has always been the route into midwifery with the first schools of midwifery being established in the sixteenth and seventeenth centuries (Hilary 1993). Midwifery as a separate autonomous profession has been recognised in legislation since the eighteenth century and midwives are recognised by government as the main provider of services to women experiencing ‘physiological’ pregnancy and birth (Abraham-Van der Mark 1993).

In New Zealand, direct entry to the midwifery profession was realised in 1991 (Pairman 1999). In the decade previous to that, the profession had striven to separate the education of midwives from
nurses and this was achieved by 1989 when a separate one year programme of midwifery education became available for nurses wishing to register as midwives. Concurrently, as major changes took place in the delivery of maternity services and in the role of midwives, the consumers of the maternity services, women “challenged midwives to think beyond this to direct entry midwifery” (Pairman, 1999). Four programmes commenced in 1991.

Canada, until the end of the 20th century had no legal provision for the practice of midwifery (Leap et al 2002). The majority of women birthed in hospital under the care of obstetricians and obstetric nurses. During the 1970's and 1980's women and midwives successfully campaigned for the legalisation of midwifery and the delivery of maternity services that were women centred. In 1991 legislation, Regulated Health Professions Act 1991, enabled the establishment of the profession of midwifery, initially in the province of Ontario and subsequently in other provinces and territories of Canada. Accordingly, midwifery education programmes for entry to the profession were developed as well as programme up skilling the competencies of midwives trained in other countries and working in Canada. Direct entry to midwifery has been the route chosen to educate entrants to the profession. This followed on the recommendations of a government taskforce set up to report on the implementation of midwifery in Ontario (Leap et al 2002) which concluded, following research into midwifery education internationally, that direct entry to the profession would ensure the best use of resources for the education of midwives as the lead professional in the delivery of maternity care. By the end of the 20th century ‘direct entry’ to midwifery programmes were established in Ontario, Quebec and were about to be in British Columbia (Leap et al 2002).

In the United States of America, the medicalisation of birth and the move from home to hospital as the place of birth also occurred in the first half of the 20th century with only 4.5% of births taking place at home by the 1950s (Leap et al 2002). Medicine (obstetricians, gynaecologists and family practitioners) established a dominant position as the lead professional in the control and delivery of maternity care and this remain the case today (Davis-Floyd 2002). Midwives aligned themselves with nursing, adopting the British model of combining nursing and midwifery, in order to retain their identity and strength against the medical profession. Midwives slowly gained recognition and established themselves as nurse-midwives. In 1955 nurse-midwives founded the American College of Nurse-Midwives and pursued the legalisation of the practice of midwifery by nurse-midwives against strong medical opposition. They achieved this and now have legal status in all states and
districts in the USA. Although nurse-midwives have their roots in home birth during the early part of the twentieth century, as birth moved from home to hospital, they also moved believing that midwifery would be best positioned within the health care system (Davis-Floyd 2002). The number of births attended by nurse-midwives has continued to rise during the twentieth century and the evidence is growing that they provide effective care with good outcomes. Currently they are the lead professional in approximately 7% of births in the USA, the majority of which are hospital birth, with some in stand alone birth centres and in the home. During 1960s and 1970s, women with no birth experience or training began to attend birth in the home in response to demand. These ‘lay’ midwives began to develop a ‘different’ knowledge base founded on birth at home and undertook to educate themselves and train apprentices (Davis-Floyd 2002). The writing of Ina May Gaskin (1990) and Elizabeth Davis (1997) provide insights into this ‘movement’ and its belief system with regard to birth and midwifery practice. The Midwives’ Alliance of North America was formed in 1982 with the purpose of providing a forum for ‘lay’ midwives not only in the USA but also Canada and Mexico. These midwives began to reject the term ‘lay’ and eventually referred to themselves as ‘Direct Entry Midwife’ (DEM). Thus the term ‘direct entry midwife’, especially for members of MANA, refers to midwives who are not nurses, have been educated through apprenticeships, practise in accordance with the midwifery model of care and attend birth in the home. Direct entry midwives have legal status in 14 states, are not legally defined but neither are they prohibited from practising in 19 further states, licensure to practise is not available in 8 states thus effectively prohibiting them, and are illegal in 9 states and the district of Columbia (Davis-Floyd 2002). Thus ‘two distinct and polarised routes of entry to midwifery practice’ have emerged in the USA during the twentieth century (Leap et al 2002) and these two groups of midwives for the most part practise in a distinct place of birth, nurse-midwives in hospital and direct entry midwives in the home. Both groups have different educational programmes for entry to the profession. The American College of Nurse-Midwives support university based/affiliated midwifery programmes and in the establishment of ‘direct entry’ midwifery programmes require an undergraduate degree as an entry requirement or to be awarded on completion of the programme. In contrast, the Midwives Alliance of North America oppose this view as being exclusive and instead have established separate certification and programme accreditation processes. These processes facilitate multiple routes of entry to midwifery including apprenticeship, self study, private schools of midwifery (Seattle Midwifery School, established in 1978), college and university based programmes, and nurse-midwifery (Leap et al 2002). Currently both bodies accredit and certify ‘direct entry’ midwifery. However they are unable to agree on standards for the education and practice of the profession (Leap et al 2002).
Direct entry to midwifery was due to be rolled out in Australia during 2002 and 2003 with eight universities preparing to begin a three year Bachelor of Midwifery (Leap et al 2002). For two decades concerns were expressed about the standards of midwifery education in Australia particularly when compared with other countries (Leap et al 2002). A lack of regulation with regard to the accreditation of midwifery education programmes has lead to inconsistencies between programme and the level of competence of the midwife at the point of qualification. The integration of midwifery education within the university system has appeared to compound the problem with it becoming subsumed within nursing. Midwifery has been seen to build on a nursing degree and students often study midwifery part-time while practising full-time as a nurse. Attrition rates are high from these programmes and Australia is experiencing a shortage of midwives. The Australian College of Midwives Inc (ACMI) Bachelor of Midwifery Taskforce was set up to develop national standards for the accreditation of the Bachelor of Midwifery so as to establish a comparable educational framework and outcomes across programmes. It is envisaged that ‘direct entry to midwifery’ will address standards of education and practice, recruitment and retention of midwives, and provide midwives capable of providing innovative models of maternity care (Leap et al 2002).

3.3 Overview of evaluations of ‘Direct Entry to Midwifery’ programmes

In reviewing the research in relation to the evaluation of ‘direct entry to midwifery’ programmes two evaluation will be presented here. These evaluations were carried out in the United Kingdom during the 1990s, the first commissioned by the Department of Health – Direct but Different: An evaluation of the implementation of Pro-registration Midwifery Education in England: A research report for the Department of Health (Kent MacKeith Maggs 1994) – and the second commissioned by the English National Board – An outcome evaluation of the effectiveness of pre-registration midwifery programmes of education (Fraser Murphy Worth-Butler 1997).

In 1989 the Department of Health in the UK provided funding for each Health Region (14) in England to develop at least one ‘direct entry to midwifery’ programme with the intention of evaluation these programmes before funding any further expansion (Fraser Murphy Worth-Butler 1997). In 1990 it commissioned a three year study into the implementation of these programmes (Kent MacKeith Maggs 1994). The purpose of the evaluation was to explore the workforce implication of and views of those involved in pre-registration midwifery education. A case study approach was used to explore six of the fourteen sites delivering the programmes. The cases were
selected to reflect diversity in relation to the structure and organisation of the institutions delivering the programmes, links with higher education, academic level, arrangements for shared learning with other health professionals, student numbers etc. Data were collected using multiple methods from the six sites and also at national level. In each case study site the data collected comprised of: interviews (semi-structured) with key stakeholders – midwife teachers, mentors, midwifery service managers, clinical managers, students, non-midwife teachers and obstetricians; and analysis of the programme curricular document. A national survey was undertaken to examine the regional policy on midwifery education; to profile the characteristics of all pre-registration midwifery students, midwife teachers and non midwife teachers, directors of midwifery and clinical midwife managers who were participating/involved in programmes up to April 1993; and to provide an overview of the features of the curriculum for the other sites besides the six case study sites offering ‘direct entry’ midwifery programmes.

Five principle areas emerged from the findings of this evaluation: policy developments; institutional arrangements; curricular design; workforce issues; and professional ideology (Maggs 1994). A major influence on policy developments, which resulted in midwives maintaining control of their education and opting for a ‘direct entry’ route, was the introduction of Project 2000 and the decision of the midwifery profession not to become a branch of nursing. However concurrently with the development of ‘direct entry’ programmes, midwifery education merged with nursing in Higher Education Institutions (HEI) and there was a sense that the new developments in midwifery education were ‘overshadowed’ and that ‘midwifery was very largely taken along on the coat-tails of nursing in the linkages with higher education’ (Kent MacKeith Maggs 1994 p13). Conjoint validation of the programmes by the higher education institutions and the professional body, the English National Board for Nursing, Midwifery and Health Visiting (ENB) was not without difficulties, especially in relation to the assessment process, with the ENB perceived as not understanding the assessment requirements for diploma/ degree and the HEI the intricacy and value of professional practice. Another policy development (Working Paper 10) that had an impact was the devolving of the commissioning of education to the employers, thus creating a clear link between workforce planning and funding for education. However this evaluation did not demonstrate that this was happening and that rather than a planned expansion of ‘direct entry’, it appeared opportunistic. In relation to institutional arrangements, midwives in HEI found themselves small in number and with little influence in decision making. Moving midwifery education into HEI had resulted in a separation of education from service and this was further compounded and affected the students’
education experience if education had a number of service sites rather than one, making collaboration difficult. Curricular design revealed that an academic award, diploma or degree, was attached to all programme but the rationale for awarding either was not clear and appeared to depend on the HEI. However in relation to the assessment process, a distinction separation was evident in the assessment of the theoretical and practice components in degree programmes that was not evident in diploma programmes. The need to acquire nursing skills also caused the students frustration especially if this occurred early in the programme. Work force issues resulting from the Working Paper 10 and Changing Childbirth Report were difficult to separate out from the introduction of ‘direct entry’ programmes and it was not clear how many midwives were needed. Recruitment to the programmes was good but there were concerns that it did not result in an even ethnic spread. There were also concerns regarding the employment prospect for these midwives. Finally, many saw ‘direct entry’ midwifery as the way forward to providing improved midwifery services with the midwife as the lead professional. There was concern that a predominantly hospital based education would not provide this midwife with the knowledge, skills, attitudes and values to best implement the recommendation in Changing Childbirth Report. Kent MacKeith Maggs (1994) concluded that there remained a need to clarify the essence of midwifery knowledge and skills and how best a student might learn these.

In contrast to the evaluation commissioned by the Department of Health, which was mainly concerned with the processes of implementation of ‘direct entry to midwifery’ programmes, the evaluation commissioned by the English National Board for Nursing, Midwifery and Health Visiting was concerned with the effectiveness of the programmes (Fraser Murphy Worth-Butler 1997). This evaluation was also of a three year duration and took a similar approach to that of Kent MacKeith Maggs (1994). A case study approach was selected and similarly 6 case study sites were selected from the thirty programmes in progress at the time of the commencement of the study. The overall aim of the evaluation was to review the programmes in existence and to study a cohort of midwives in the first year following completion of one of the programmes. The study was divided into two phases: phase one was concerned with an examination of the curricula of the six case studies, the identification and development of new tools for the assessment of outcomes of midwifery programmes of education, and an assessment of the intended and actual outcomes of the programmes in terms of knowledge, attitudes, competencies and skills. Phase two involved an evaluation of the effectiveness of the programmes in terms of knowledge attitudes competencies and skill one year on, identification of the continuing educational needs of these midwives, and
identification of retention rates, career patterns and intention of midwives qualified via these programmes since 1992. One of the major parts of this evaluation was the development of a model of competency against which the programmes could be evaluated. This was achieved by a review of the literature, a conference to stimulate debate with key note paper from experts in the area of competence, and views from the key stakeholders – women and their families, midwifery students, midwives, midwife teachers etc. The model was then used as a framework to organise the data collected.

The examination of the curricula revealed similar content, a student centred approach to learning, varied teaching methods, and an emphasis on life long learning and research. Whilst there was an underlying philosophy within the programmes to integrate theory and practice, the curricula revealed that there was frontloading of theory in the early part of the programme, with the ‘compartmentalisation’ of subjects. In relation to the outcomes of the programmes and their effectiveness data were collected from the cohort of midwifery students, their midwife teachers and assessors during the programme and again 4-5 months and one year following registration along with midwives who worked closely with them and their midwifery supervisor or manager. The intended outcomes of curricula were similar and were congruent with the model of competence develop. Attrition was found to be 30% overall, was most likely to occur in the first year of the programmes and those students who chose to leave did so for family reasons. Ensuring that students understood the demands of the programme was identified as a problem. Midwives qualifying from the programmes were found to be committed to the midwifery model of care i.e. a woman centred approach drawing on a ‘problem solving, partnership approach’ and demonstrated an enthusiasm for midwifery and continuing personal and professional development. They had a sound knowledge base and understanding of research. At the point of registration confidence in their ability to practice as a midwife decreased but this was quickly regained especially if supported. This support was particularly needed in labour ward and by the least confident midwives. Programmes that facilitated students ‘to be a midwife’ before the end helped with the transition. Some had had limited experience in planning and evaluating care and found it difficult to prioritise and manage time in a busy maternity unit. The competencies achieved in certain skills i.e. catheterisation, episiotomy, epidural top-up and drug administration, were not at a level to allow midwives undertake these without assistance; however, they were anxious to learn any skill they had not acquired in order to provide holistic continuity of care to women. It was recommended that students be exposed to midwifery practice placements early in programmes and participate rather
than just be an observer. A small number of students were identified as being borderline at the point of registration and had still not achieved acceptable standards in the first year in practice. The findings suggest that midwives in practice find it difficult to ‘fail’ students especially if they feel ill prepared for the role, lack confidence in their judgement, are not supported by teachers and do not know the student well. There is often a lack of documented evidence to support concerns about a student. During the first year in practice over half the midwives felt that they were adequately supported and by the end of the year were described as confident competent midwives.

3.4 Strengths and weakness of ‘Direct Entry to Midwifery’

At the point of registration the evaluations of ‘direct entry’ to midwifery programmes have identified that midwives educated through this route are committed to providing woman centred midwifery care, have a sound knowledge base and demonstrated an enthusiasm for midwifery. There are concerns about their level of competence in undertaking certain skills and their ability to prioritise and manage their time in busy maternity units. However, with support, these shortcomings appear to be overcome within the first year in practice. In report of the final evaluation, a review of outcome evaluations of similar programmes for profession practice will be undertaken and, in particular, the ability to assume full responsibility and accountability at the point of registration will be explored as well as the level of support needed to achieve this.

3.5 Discussion and conclusion

A preliminary review of the pertinent literature has been undertaken for the purposes of the preparation of this evaluation report. From the review of the international perspectives on midwifery care and the education of midwives, it would appear where women demand midwifery services the preparation of midwives is through the direct route and that this is seen as the most appropriate. One country, Canada, has introduced this route as being the best use of resources, however there is little published about the cost effectiveness of educating midwives through the direct route. Kent, MacKeith Maggs (1994) found in their evaluation of ‘direct entry’ programmes that the actual costs of the programmes were not clear. The two evaluations reviewed have researched the implementation from two different perspectives: the structure and process of implementing ‘direct entry to midwifery’ programmes, and an evaluation of the outcomes of the effectiveness of these programmes.
3.5.1 Recommendations

Final evaluation

- Undertake a comprehensive review of the literature on ‘direct entry’ to midwifery;
- Undertake a review of outcome evaluation of other health professional programmes with emphasis on the first year in practice identifying level of competence and supports needed.
Chapter Four

Methods

4.1 Introduction

The aim of the evaluation is to describe the development, delivery and ‘effectiveness in practice’ of a pilot programme of direct entry into midwifery in Ireland and to determine the characteristics and the issues that are essential to the effectiveness of the programme and the issues that need to be reconsidered. Because of the uniqueness of this programme within the Irish context and its status as a pilot programme, the Department of Health and Children has specifically requested that the programme be evaluated and a report prepared for the Department by the 31st July 2003, two months following completion of the pilot programme. An interim evaluation was undertaken at the midpoint in the programme in order to prepare for the final evaluation. This chapter details the research design and method of the final evaluation.

4.2 Research design

Case study research has been selected as the approach to evaluate the development, delivery and effectiveness of the pilot programme. Case study research is not considered a method or design but rather a strategy (Pegram 1999, Hammersley and Gomm 2000) and can cross both the quantitative and qualitative paradigms (Yin 1994). This approach allows for, depending on the level, the description, exploration and explanation of single or multiple cases, in this instance a single case – the pilot programme of Direct Entry to Midwifery. However, even though it may involve a single case, it may be concerned with numerous variables (Bryar 1999). A case study approach has been used in the two large studies evaluating Direct Entry to Midwifery programmes in England (Kent et al 1994, Fraser et al 1997).

4.3 Access to the research site

Before the commencement of the programme permission was sought from the Direct Entry to Midwifery Committee to approach key stakeholders in relation to the evaluation of the programme. This was granted. Details of the evaluation process were presented and discussed on an ongoing basis at meetings of the committee. During recruitment and again at interview, potential candidates
were informed of the pilot nature of the programme and that evaluation would be an ongoing process during the programme.

4.4 Research population

All key stakeholders in the two linked maternity units constituted the population. This included: ‘direct entry’ midwifery students, Postgraduate Diploma in Midwifery students in the two linked schools of midwifery, midwives (in the areas where direct entry students had practised), midwife managers and midwife teachers (including a number of teachers who had left or retired). All members of these groups were included in the study. Obstetrician and paediatricians were also included and convenient sampling was used. Short interviews were carried out with two consultant obstetrician and one consultant paediatrician.

4.5 Methods of data collection

Case study research allows for the use of multiple methods of data collection and in this evaluation data were collected using the following: structured questionnaire, focus group interview, interview, evaluations of aspects of the programme (evaluation by preceptors and ‘direct entry’ midwifery students of the preceptorship period, and evaluations of external placements), minutes of meetings, correspondences etc. In seeking the views of key stakeholders regarding the development and delivery of the programme, two main methods of data collection were employed: structured questionnaire and focus group interview. A structured questionnaire containing mainly closed questions was developed and administered to all key stakeholders. Following analysis of these data the findings were used to develop structured interview guides for focus group interview. The use of both methods provided the opportunity to generate a breadth and depth of data. The structured questionnaires initially generated focused data; this was then used in the focus group interviews with each group of stakeholders to explore issues in depth. The use of focus group interviews also facilitated the exploration of issues not addressed in the questionnaires.

4.5.1 Development of data collection instruments

Five questionnaires were developed – ‘direct entry’ midwifery students, Postgraduate Diploma in Midwifery students, midwives, midwife teachers and midwife managers. A number of evaluation tools were reviewed (Kent et al 1994, McEvoy 1995, Fraser et al 1997). The structure of the tools used by McEvoy (1995) was finally used to develop the questionnaires for a number of reasons: it
used closed questions contributing to easy analysis, and a structure that is well used in curriculum evaluations, that of ‘structure, process, outcomes’. Although the wording of the questions in the questionnaires of this evaluation is significantly different, permission was sought from the National Board for Nursing, Midwifery and Health Visiting for Northern Ireland to include some of the questions from the questionnaires developed by McEvoy. No response to this request was received although a letter was sent on 18th October 2001 and a number of phone calls were made. Attempts have also been made to contact Catherine McEvoy directly without success. For the interim evaluation, the questionnaires were reviewed by a number of individuals from each group during November 2001 and few changes were required. They were then used to collect data as part of the interim evaluation. Following the completion of the report of the interim evaluation, the content and structure of the questionnaires were revised and expanded on based on the contribution made to clarity/confusion in that report. Again a number of members of each group reviewed the relevant questionnaire for clarity and comprehensiveness. Minor adjustments were made. Two individuals external to the evaluation then reviewed them: the external examiner for the programme and a midwife who has undertaken evaluation of ‘direct entry’ to midwifery programmes in Scotland. They viewed the instruments as comprehensive and one commented that the only issue to consider was the length of the questionnaire to midwives.

Following data analysis of the questionnaires, focus group interviews were organised with each group of key stakeholders: ‘direct entry’ midwifery students, midwives (two groups, one each in The Rotunda Hospital and Our Lady of Lourdes, Drogheda), midwife managers and midwife teachers. Structured interview guides was prepared for each group interview arising out of the preliminary findings from that group’s questionnaires.

Evaluation is an integral part of the delivery of any programme and the evaluations that were carried out have been used to inform parts of this evaluation, in particular the evaluation of the preceptorship period and the external placements. Evaluation tools were developed specifically for this purpose.

**4.5.2 Reliability and validity of the data collection instruments**

**4.5.3 Data collection and response rates**
There are three main points when data were collected from key stakeholders that comprises the compilation of this report:

1. The preceptorship period;
2. External placements (18th February to 19th May 2002);
3. Final evaluation.

Data collected at the midpoint in the programme was presented in the interim evaluation and is referred to in this report, where appropriate. During the preceptorship period, data were collected from the preceptors at 4 points and from the midwifery students at 2 points. As noted in Table 4.1 the response rates at each of these points were excellent except that from the preceptors at the endpoint point evaluation.

Table 4.1 Preceptorship period - response rates

<table>
<thead>
<tr>
<th>Evaluation points</th>
<th>Preceptors N = 13</th>
<th>Midwifery students N = 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-programme evaluation</td>
<td>13 100%</td>
<td>-</td>
</tr>
<tr>
<td>Post-programme evaluation</td>
<td>13 100%</td>
<td>-</td>
</tr>
<tr>
<td>Preceptorship Period - Midpoint evaluation</td>
<td>12 92% 19 * 100%</td>
<td>19 100%</td>
</tr>
<tr>
<td>Preceptorship Period - Endpoint evaluation</td>
<td>7 54% 18 95%</td>
<td></td>
</tr>
</tbody>
</table>

* (1 student had left the programme at the beginning of the preceptorship period)

A day had been allocated to the midpoint evaluation, and completion of the questionnaires was part of the programme. In comparison, a half day was allocated to the endpoint evaluation with questionnaires distributed prior to this. On the day of the evaluation a number of preceptors had not completed the questionnaire and they were encouraged to complete and return it. As there was no identification number on the evaluation forms it was not possible to follow up non-responders.

Data for the final evaluation was collected between June and the end of August 2003 as it was deemed important that the programme was completed before this process commenced. However, the questionnaires to ‘direct entry’ midwifery students were distributed on their last day on the programme (24th May 2003). This did result in a short time frame in which to distribute and collect questionnaires, data entry and analysis of questionnaires, preparation for and undertaking the focus group interviews and interviews, and finally writing the report. Table 4.2 illustrates the groups of
key stakeholders to whom questionnaires were sent and the subsequent response rate. Questionnaires were addressed personally to each individual. Boxes/files to return the questionnaires were placed in strategic points for each groups. The researcher visited regularly to collect completed questionnaires and to encourage staff to complete the evaluation. This also provided an opportunity to provide information on the evaluation process. In the interim evaluation the response rate from midwives (22%) was disappointing. In an attempt to increase the response rate for the final evaluation, an incentive was introduced and those returning the questionnaire were entered into a draw for a €100 voucher. Again, in order to preserve anonymity, it was not possible to identify non-responders and send a reminder. The researcher appreciated the assistance from

midwife managers in encouraging staff to complete the evaluation. The response rate from midwives (40%) probably reflects the amount of contact some midwives had with ‘direct entry’ midwifery students and this was mentioned to the researcher on a number of occasions.

In relation to the evaluation of external placements, 12 of the 15 (80%) midwifery students remaining in the programme completed the evaluation, and completed evaluations were received from all but one of the external placements.

### 4.6 Ethical considerations

As already stated, before the commencement of the programme permission was sought from the Direct Entry to Midwifery Committee to approach key stakeholders in relation to the evaluation of the programme. This was granted. Ethical approval was sought and granted by the Ethics Committee, School of Nursing and Midwifery Studies. The evaluation was governed by the principles of beneficience, non-maleficence, respect and justice.
4.6.1 Informed consent

Consent was viewed as an ongoing process, which required negotiation throughout all aspects of the evaluation. All participants were given both written and, and in the case of the focus group interviews, verbal information about the evaluation. The evaluation was explained, including aim, purpose, methods and procedures for data collection and the procedure for protecting their identity. Participants were informed that they had the right to withdraw at any stage.

A letter detailing the evaluation aim, purpose, methods and procedures for data collection and the procedure for protecting their identity accompanied the questionnaire. The researcher's contact details was provided and the letter and the participants invited to contact the researcher if they wish to seek further clarification about the evaluation and/or the implications for them of participating. Participants had 2 weeks in which to complete and return the questionnaire. Return of the questionnaire was taken as indicating consent to participate in the evaluation.

For participants engaging in the focus group interview, a letter of invitation and an information sheet was sent to each participant. Prior to the start of the interview: a detailed explanation about the process was reiterated and participants were informed that they had the right to withdraw at any stage without obligation. Participants who might decide to withdraw were informed that any data recorded from them so far in the interview, would be deleted from the transcript of the interview. They were also informed that if they wished to explain why they wished to withdraw the interviewer would be happy to listen, but at no stage would the interviewer try to get them to change their mind. Participants were also given an opportunity to ask questions and seek clarification on issues before the interview began. Participants were reminded that they were free to ask questions as they occur during their participation. Each participant was also asked to sign a consent form prior to the interview, consenting to be interviewed and tape recorded. After the interview the participants were again reminded that their participation was voluntary and that they could still ask for information, which they had given, not be used.

4.6.2 Maintaining confidentiality

All participants have the right to privacy. Maintaining confidentiality and anonymity is of paramount importance given that this evaluation involves one programme with very small numbers of participants within certain groups of key stakeholders i.e. ‘direct entry’ midwifery students, managers, teachers. For this reason, it was been decided not to place any identifying mark on
questionnaires. It was, however, necessary to do so for the evaluation of the external placements in order to match the students’ evaluation of a specific placement with the evaluation of the students by the placement. Information regarding each specific placement is essential for future planning of external placements. The names and contact information of each participant was kept in a secure location. As the questionnaires did not include an identification number, the researcher was unable to link returned questionnaires to an individual. The researcher remaindered individuals to complete and return the questionnaire when she visited the maternity hospitals to collect the completed questionnaires. Separate envelopes were provided for the return of the form indicating willingness to participate in the focus group interviews and for entry into the draw. In the transcripts of the focus group interviews participants were not identified or allocated a pseudonym. In order to preserve privacy the record of consent signed by those participating in the focus group interviews were stored in a locked, secure press away from the questionnaires, tapes and written transcripts. Because the researcher was the Course Co-ordinator who had close contact with many of the key stakeholders the issue of recognition of a respondent’s writing also needed to be considered to avoid bias and maintain anonymity. In order to avoid this, transfer of data from questionnaires into computer files for the purposes of data analysis and interpretation was performed by an external agency. An individual unlikely to know the participants performed the transcribing of the recorded focus group interviews. Only the transcripts and not the original data was used during analysis.

Questionnaires, tape recordings and written copies of transcripts (hard copies) were stored in a locked cabinet. Data on the computer was password protected. All data was stored in accordance with the data protection act (1988). In the final report, careful attention was given to ensure that all other information cited in the report did not identify the participants. Participants’ names, addresses and consent forms will be destroyed once the evaluation has been completed.

4.6.3 Participants autonomy

Autonomy was maintained by providing sufficient information to the participants to enable them make an informed choice. All participants were free to decline to be involved, without feeling they were being overtly or covertly coerced.

4.6.4 Avoidance of harm

It was not anticipated that completion of the questionnaire would cause participants any undue distress. Careful consideration was given to the design of the questions. In relation to the focus
group interviews, before each interview begins the group will be asked to agree a set of ground rules in order to ensure an atmosphere of mutual respect and enable each participant to participate

4.6.5 Justice
All key stakeholders were invited to participate in this evaluation. Participation was voluntary. The researcher did not put any undue pressure on any individual to participate. Questionnaires did not have identifying marks. Participants were asked to return the form indicating willingness to participate in a focus group interview separately. The researcher was available throughout the evaluation to answer/discuss issues. Representative of all groups of participants were members of the Direct Entry to Midwifery Committee, which had the responsibility for overseeing the evaluation. Participants will have access to the final report.

4.7 Data analysis
The services of a research consultant were employed for the purposes of data entry and analysis of the questionnaires to key stakeholders. Tables for each question on each questionnaire was first generated and then, where the same question had been asked of a number of a number of groups tables of the combined responses were generated. The data are presented as descriptive findings. No attempt has been made to perform statistical analysis comparing the responses between group given the small numbers in three of the four main groups i.e. ‘direct entry’ midwifery students, midwife managers and teachers. Graphs and tables have been used to display the data.

Data from the focus group interviews were transcribed into Microsoft Word Documents. The responses to each question were summarised and were presented to explain/illuminate the findings from the questionnaires.

Data from the evaluation forms comprised mainly open questions and had been transcribed into Microsoft Word Documents.
5.1 Introduction

This chapter provides an outline of the context within which the preparation for the development and delivery of this programme of direct entry to midwifery took place. From the outset efforts were made, through the consultative process by An Bord Altranais, to ensure that the development of this pilot programme contained the aspirations of midwives in Ireland regarding the education of those entering the profession. Following the selection of the pilot site efforts continued to ensure that all involved, directly and indirectly, in the development and delivery of the pilot programme ‘felt involved’. The short lead in time would appear to have negatively impacted on this as will be evidenced in the findings presented in this chapter. However, it would appear that as development of the programme continued (almost simultaneous as the delivery of the programme) there was a sense amongst all key stakeholders that their views impacted on the development of the programme.

As the Report of the Commission on Nursing recommended this development, the events that immediately followed its publication are synopsised. The role of An Bord Altranais in carrying forward the recommendation of the Commission is then detailed. An overview is provided of the decisions regarding the selection of the pilot site, the delivery of the programme at diploma level and the partnership arrangement. The design of the curricular model and the subsequent development of the curriculum is presented. Finally, the findings from the evaluation regarding the structure, process and outcomes of the development of the programme are detailed.

5.2 Initiation of a Direct Entry to Midwifery Programme

The Report of the Commission on Nursing recommended that An Bord Altranais pilot a programme of Direct Entry to Midwifery. In response to this and other recommendations relating to midwifery, An Bord Altranais set up the Midwifery Sub-committee, one of its remits being to carry forward the recommendations of the Commission in relation to midwifery education. Dr. Cecily Begley, Director of the School of Nursing and Midwifery Studies, Trinity College was co-opted on to the committee. A sub-committee (Direct Entry Sub-committee) of this committee was
set up with the sole remit of developing a programme of education and in so doing to consult widely with the profession. Consultation began in early 1999 and involved meetings with the profession as a whole: midwives, educationalists (both schools of midwifery and third level institutions) and managers, with the aim of developing a shared philosophy for the programme. Meeting were held with midwife managers and educationalists as a group and with midwives. An attempt was made to invite every midwife to these meetings. Consultation was somewhat limited in that a budget was not provided for it.

A tentative philosophy for the programme began to emerge from the consultation process with two recurring themes: 1. midwifery practice should be central to the programme with early exposure of midwifery students in practice; and 2. a mechanism of preceptorship should be put in place to ensure a practice environment conducive to learning and to support midwifery students. A proposal for the programme was developed by the committee and presented to the Midwifery Sub-committee at its meeting on 21st June 1999. The committee agreed the proposal and Dr. Cecily Begley was asked to forward the proposal with costing to the Department of Health and Children.

The Department of Health and Children, on the 11th November 1999, approved the piloting of a Direct Entry to Midwifery Programme at diploma level. An Bord Altranais gave its approval at a board meeting on 9th December 1999. A change was required to the Nurses Rules, 1998 of the Nurses Act, 1985 to include a direct entry programme as a route to registration as a midwife. These changes were presented to An Bord, approved and signed by the Minister of Health and Children on 10th February 2000. The Requirements and Standards for the Midwife Registration Education programme were also amended to include direct entry to midwifery.

5.3 Selection of the pilot site

Following the publication of the Report of the Commission on Nursing (1998), Dr Cecily Begley indicated to the Department of Health and Children an interest in developing and delivering a programme of Direct Entry to Midwifery in the School of Nursing and Midwifery Studies, The University of Dublin, Trinity College. Prior to submitting this request, informal discussions had taken place between Dr. Begley and the midwifery personnel in the two linked maternity hospitals, The Rotunda Hospital, Dublin and Our Lady of Lourdes, Louth/Meath Hospital Group, NEHB, Drogheda, and there was general agreement to being part of the development and delivery of the
pilot programme. The department responded with a request to design a suitable programme with a view to offering the programme on a pilot basis in the next academic year (1999).

In November 1998, Dr. Begley was co-opted as a member of the Midwifery Sub-committee, An Bord Altranais, and subsequently as a member of the Direct Entry Sub-committee. At a meeting of the Sub-committee in 1999, it was decided that a request for proposals to run this programme be sought from other third level institutions and their linked maternity hospitals. Although individuals expressed interest, no further bids were made to this request. Concurrently, this was a time of industrial unrest within the health services, culminating in a strike of nurses and midwives toward the end of October 1999. Implementation of the recommendations regarding midwifery education in the Report of the Commission on Nursing: the pilot Direct Entry to Midwifery programme and the increase in the theoretical component of the post registration midwife education programme, were among the non-pay items in the settlement of the strike.

On the 15th November 1999 Mr. Bernard Carey, Principal Officer, Nurses Policy Division, Department of Health and Children wrote to the Provost of the University of Dublin, Trinity College requesting that they take on this programme to commence 1st June 2002. As detailed in the minutes of the Council of the University of Dublin, Trinity College, approval to the proposal was granted on 9th February 2000. At a meeting on the 14th December 1999 to discuss the proposal, midwife managers and teachers from The Rotunda Hospital and Our Lady of Lourdes, Drogheda discussed and welcomed the pilot programme in partnership with the School of Nursing and Midwifery Studies, Trinity College.

5.4 A diploma in midwifery

During the consultation process, the desire of the profession was that this education programme would be at graduate rather than at diploma level. The Direct Entry Sub-committee had made this recommendation to the Midwifery Sub-committee at the meeting on 21st June 1999. However, following discussion it was decided that the recommendation as detailed by the Commission on Nursing Report should be implemented and was thus recommended to the Department of Health and Children. The Department has stated in a letter to Dr. Begley that the programme will be developed at degree level after 2002 if, following successful completion and evaluation, the decision is taken to proceed with ‘direct entry’ as a route into the midwifery profession.
5.5 Resources

The following resources were agreed for the development, delivery and evaluation of the programme:

- Course Co-ordinator x 3 year and 6 months + supports (set-up and secretarial);
- Midwife teacher x 4 months to assist with the initial development;
- 1.25 WTE Midwife Teacher (0.75 to The Rotunda and 0.5 to Drogheda);
- Preceptors x 13 x 19 weeks;
- Costs of the evaluation;
- Fees, grant, book, uniform and travel allowances x 20 midwifery students;
- Recruitment and selection costs;
- Salaries x 20 students x 36 weeks in year three at the level of a third year nursing student.

The actual costs relating to the development and delivery of the programme are detailed in Chapter Nine.

5.6 Memorandum of Understanding

A Memorandum of Understanding was drawn up detailing the partnership agreement between the School of Nursing and Midwifery Studies, University of Dublin, Trinity College, Our Lady of Lourdes, Louth/Meath Hospital Group, NEHB, Drogheda and The Rotunda Hospital. Mr Bernard Carey, at a meeting of the Direct Entry to Midwifery Steering Committee on 20\textsuperscript{th} March 2000, advised a tripartite agreement be drawn up and submitted for the legal opinion of the three partners. The memorandum was signed at a ceremony in The Rotunda Hospital, on 8\textsuperscript{th} March 2001. The signatures to the memorandum were: The Master and Director of Midwifery, The Rotunda Hospital; Deputy Chief Executive Officer, North Eastern Health Board and Director of Nursing and Midwifery Services, Our Lady of Lourdes Louth/Meath Hospital Group, NEHB, Drogheda; and from The University of Dublin Trinity College: Secretary to the College, Dean of the Faculty of Health Sciences, and Director, School of Nursing and Midwifery Studies.

5.7 Curriculum design

The pilot programme was at diploma level and was of three years duration. A detailed review of the literature on midwifery education curricula was undertaken. Other countries, the UK and New Zealand in particular, had been delivering Direct Entry to Midwifery Programmes since 1989 and it was felt that exposure to their experiences and evaluation processes would be most useful to the development of an Irish curriculum. Having reviewed the literature and research that exists on pre-
registration midwifery education programmes and having discussed the Irish situation with experts in other countries, a feature that frequently recurred was the limitations and restrictions imposed by systems that appeared to separate rather than integrate the theory and practice of midwifery. The cause of these limitations were frequently cited as the modularisation and semesterisation of the education programmes that leads to a fragmentation of the programme as a whole.

A second recurring feature from the literature and research was the desire to provide a programme that integrates practice and theory but also provides students with theory on which to base their practice. This however had resulted in frontloading programme with theory, especially the sciences, and eclipsing the philosophical perspective of the integration of practice and theory. Fraser et al (1997), in an analysis of curricular documents as part of a national evaluation of direct entry midwifery programmes in England, identified a dichotomy between the stated philosophy and its implementation, evidenced by a front loading of theory (scientific) with practice coming later. An evaluation of the first Diploma in Nursing programmes in Ireland highlighted a similar ‘problem’ again with the frontloading of the programme with the sciences and students not being afforded the opportunity to experience practice until six months into the programme (Simons et al 1998).

With these issues in mind and the aspiration that the programme would be practice focused with true integration of practice and theory and consequently the immersion of the midwifery student in practice from early in the programme, the curricular model emerged (see Figure 5.1). The curriculum placed its entire emphasis on midwifery practice. Detail of the structure (allocation to classroom/practice) of the programme is provided in Appendix I. This midwifery education programme centred on four main themes:

(i) core midwifery practice;
(ii) rationalising midwifery practice;
(iii) analysing and critiquing midwifery practice
(iv) developing decision making skills in midwifery practice.

The emphasis placed upon each theme varied throughout the programme: in the first year the focus was on core midwifery practice whilst in the third year the focus was on developing decision making skills. It was acknowledged that these themes were interwoven and inextricably linked and did not exist in isolation from one another. For example, midwifery students needed to develop decision making skills in year one, such as accessing appropriate help and support in unforeseen situations,
Figure 5.1  Diploma in Midwifery (Direct Entry) Curricular Model

Becoming a midwife: practice and theory

<table>
<thead>
<tr>
<th>Core midwifery practice</th>
<th>Describing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationalising midwifery practice</td>
<td>Reasoning</td>
</tr>
<tr>
<td>Analysing and critiquing midwifery practice</td>
<td>Analysing</td>
</tr>
<tr>
<td>Developing decision making skills in midwifery practice</td>
<td>Informed decisions</td>
</tr>
</tbody>
</table>

Supporting Sub-themes

- **Health & Safety**
- **Ethics and law**
- **Management**
- **Sources of knowledge**
- **Pharmacology**
- **Pathophysiology**
- **and family planning**

<table>
<thead>
<tr>
<th>* Health &amp; Safety</th>
<th>* Psychology &amp; psychological well being</th>
<th>* Control systems for health</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Ethics and law</td>
<td>* Power, policies &amp; politics in Ireland</td>
<td>* Developing relationships</td>
</tr>
<tr>
<td>* Management</td>
<td>* Adaptations to pregnancy</td>
<td>* Sociology</td>
</tr>
<tr>
<td>* Sources of knowledge</td>
<td>* The midwife and midwifery profession</td>
<td>* Health Promotion</td>
</tr>
<tr>
<td>* Pharmacology</td>
<td>* Life sustaining skills</td>
<td>* Personal development</td>
</tr>
<tr>
<td>* Pathophysiology</td>
<td>* Women in Ireland: society, culture and childbearing in Ireland</td>
<td>* Sexuality, sexual health</td>
</tr>
</tbody>
</table>

Successful completion of the totality of programme = Registration as a Midwife

Continuing education and professional development
and in year three and as midwives, their practice would always be dependent on core midwifery skills. All of the aforementioned meant that these themes could not be fully assessed until the totality of the programme had been delivered.

The four practice themes were supported by eighteen sub-themes throughout the entirety of the programme and each of these sub-themes was delivered at differing and incremental levels of knowledge as the programme progressed (see Figure 5.1). In year one, all the sub-themes were alluded to, in the theory and practice components, and were delivered primarily at a descriptive level. By the end of the preceptored practice period (week twenty nine), midwifery students were expected to be able to give care without having a full understanding of the reasoning and rationale underpinning their practice. As they were practising under the constant direct supervision of a preceptor, the care that they gave would be fully supervised. Inevitably and unavoidably, midwifery students were exposed to pathophysiologies early in practice and for this reason were expected to acquire the skills of assisting with and accessing the necessary and appropriate support. During this period of preceptored practice, students were expected to develop an enthusiasm and inquisitiveness that encouraged them to seek answers to the art and science of midwifery practice. Throughout this period of practice, the skills of practice reflection, independent learning and sharing of experiences and knowledge were fostered in a timetabled structured group format. From weeks thirty seven to fifty two, midwifery students were exposed to the theoretical knowledge underpinning the acquired practice in a multidisciplinary structured learning environment interspersed with focused midwifery tutorials. At this time students were expected to be secure in their identity as midwifery students and it was expected that this period of intensive theoretical input would further address the ‘reason and rationale’ underpinning the acquired practice. During this time, students were expected to acknowledge the existence of national and international literature without, necessarily, being able to articulate its value or relevance to practice. Throughout this time, midwifery students remained in a supernumerary capacity.

From year one to year two students were expected to develop intellectual skills and attributes at a level that displayed an understanding of the rationale for practice. They were expected to refine and develop their core midwifery practice and place midwifery in the wider context of maternity services and health services in Ireland. They were expected to articulate and begin to analyse the seminal research and evidence that underpins practice as well as showing an understanding of the areas of practice that
required further deliberation and research. During this period of theory and practice, emphasis was placed upon refining and developing existing core practice and attributes as well as becoming more confident in understanding the boundaries of midwifery and obstetric practices. Midwifery students were expected to become confident in recognising reproductive, maternal and fetal physiological patterns of progression so that deviations from these were promptly recognised and reported, and appropriate decisions were implemented. Both the organised theory and practice components of this year focused on the midwifery students gaining knowledge of the wider context in which midwifery care in Ireland is placed whilst the student remained in supernumerary status.

In year three of the programme the status of the student changed to that of an employee. This significant change occurred at a time when the student had acquired competence/proficiency in core midwifery practice, understood the reasoning and rationale of midwifery practice, had begun to develop the skills of reviewing, critiquing and analysing practice, research and evidence and could now progress to developing decision making skills based upon acquired deep theory and practice knowledge. During the latter part of this final year, students were expected to develop their informed decision making skills and display theory and practice consolidation and integration of all four themes at a level necessary for registration and autonomous practice as a midwife.

5.8 Evaluation of the development of the curriculum

The initial development of the curriculum prior to the commencement of the programme was undertaken in a short time frame and the findings presented in this section are mainly concerned with this period. Curriculum development continued throughout the entirety of the programme.

5.8.1 Structures for the development of the curriculum

A number of structures were put in place to begin curricular development. As already described, a broad vision developed by the midwifery profession had been articulated and this formed the basis for the proposal for the programme submitted to and accepted by the Department of Health and Children on 11th November 1999. Three facets of the structures put in place for the development of the curriculum are identified: funding, a curriculum development committee, and input from all key stakeholders.
Funding was provided for a course co-ordinator for a three and a half year period to develop, deliver and evaluate the programme. In addition, a midwife teacher was also employed for four months to assist with the development of the programme prior to its commencement on 1st June 2000. Subsequently, additional funding of a 0.5 WTE was provided in 2001 for an 8-month period to continue to work on the ongoing development, management and implementation of the programme. In the focus group interview with midwife teachers, a number of the group felt strongly that there was insufficient set up funds to cover resources of personnel and time required to develop the programme. The personnel required and the time writing a curriculum, developing assessments, actually take had not been factored accurately into the costings. As a consequence there were not enough personnel released to help establish the programme. An Bord Altranais’s ratio of midwife teacher to midwifery students was put forward as a possible reason for this, which the group were of the opinion was not accurate.

In order to ensure the involvement of all key stakeholders in the development of this programme, a Curriculum Development Committee was set up by the Steering Committee for Midwifery Registration Education Programme (Direct Entry) at its meeting on 10th April 2000. The committee first met on 4th May 2000. When asked, the majority of key stakeholders (n=111, 71%) (‘direct entry’ midwifery students, midwives, midwife teachers and managers) agreed/strongly agreed that they had representation on committees concerned with the development of the programme.

Curriculum development that aspires to the ethos of being inclusive and collaborative impacts on the individuals involved. There must be a commitment to attend and participate at committee level as well as review and comment on the curricular document (in its broadest sense) during the development process. This requires time. This element of the structures necessary to the process was taken on in addition to individuals’ already heavy workload and without additional funding and/or personnel.

5.8.2 Process of the development of the curriculum

The process of the development of the curriculum is described in detail within the curricular document. Prior to the establishment of the Curriculum Development Committee, a detailed literature review, discussion with experts from other countries, and site visits to four programmes in the UK were undertaken.
The purpose of the establishment of the Curriculum Development Committee was to ensure the involvement of all key stakeholders and a collaborative approach to the development of the programme. The membership and terms of reference developed by the committee reflects this approach (detailed in Section 6, Curricular Document). The committee met on almost a monthly basis throughout the delivery of the programme.

The evaluation attempted to elicit the views of all key stakeholders on their involvement and the degree of collaboration experienced by them in the process of the development of the curriculum. Midwives, managers and teachers agreed/strongly agreed that there had been a high degree of collaboration between the Department of Health and Children and the three partners i.e. The University of Dublin Trinity College and its two linked maternity hospitals, The Rotunda Hospital and Our Lady Lourdes Louth/Meath Hospital Group NEHB, Drogheda (see Figure 5.2). The percentage selecting the ‘not applicable’ category may be explained by the fact that a number of personnel at the final evaluation would not have been in post in the early stages of the planning of the programme.

Figure 5.2 There was a high degree of collaborative planning between the DoH&C and the three partners (n=141)
Table 5.1 details the degree to which midwives, managers and teachers felt that they were consulted and kept informed during the planning stages of the programme (again, the percentage selecting the ‘not applicable’ category may indicate when they took up post). While a small majority agreed that they were kept informed during the planning stage the majority disagreed that they were consulted at this time. In the focus group interviews, teachers attributed this in part to the management style at that time and that although there was consultation between TCD, The Rotunda and Our Lady of Lourdes it did not necessarily follow that it fed down to all midwife teachers. Some managers stated that the limited consultation/information was due to the short lead in period. One commented: ‘I mean, we just got told it was happening and I don’t think there was sufficient time for the level of consultation and participation that would have been ideal’.

Table 5.1  Midwives, midwife managers and teachers’ views on being consulted/kept informed during the planning stages of the programme

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulted during the planning stages of the programme</td>
<td>N 15</td>
<td>49</td>
<td>23</td>
<td>13</td>
<td>29</td>
<td>12</td>
<td>141</td>
</tr>
<tr>
<td>%</td>
<td>11%</td>
<td>35%</td>
<td>16%</td>
<td>9%</td>
<td>21%</td>
<td>9%</td>
<td>100%</td>
</tr>
<tr>
<td>Kept informed during the planning stages of the programme</td>
<td>N 8</td>
<td>40</td>
<td>40</td>
<td>16</td>
<td>30</td>
<td>7</td>
<td>141</td>
</tr>
<tr>
<td>%</td>
<td>7%</td>
<td>28%</td>
<td>28%</td>
<td>11%</td>
<td>21%</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Seeking their views and ensuring that key stakeholders have a voice in the planning of the curriculum was part of the terms of reference of the Curriculum Development Committee. The degree to which this was implemented is detailed in Table ???. The majority of key stakeholders agreed/strongly agreed that their views had an impact on the ongoing development of the curriculum. However, almost equal number agreed as disagreed that their views had been sought and that they sought to have their views represented at committees. In the focus group interviews, midwives ……………In some contrast, the majority of ‘direct entry’ midwifery students felt that they had a voice in the development of the curriculum.

5.8.3 Outcome of the development of the curriculum
Three outcomes with regard to the development of the curriculum are highlighted in this section: the timeframe in which the programme was developed and any impact that had on the programme; the curriculum; and readiness to deliver the programme.

There was barely four months from the time the course co-ordinator took up post and the programme starting in which to develop the curriculum. Consequently by the 1st of June 2000 the curriculum for year one of the programme was in place with an outline of year two and three. Even for year one, by the start of the programme items such as assessment documentation i.e. guidelines, marking criteria, practice assessment documents, record of midwifery practice, etc were still being developed. However,

![Figure 5.3 The short lead in time had a negative impact on the overall development of the programme (N=141)](chart)

the majority disagreed that the short lead-in period had had a negative impact on the development of the programme. When responses are looked at individually for each group, the majority of managers agreed/strongly agreed that it did impact negatively. In the focus group interview, managers stated that it did not allow for time to prepare staff adequately especially in relation to teaching the students. One manager wondered if it was possible to address these concern anymore than had been done with
another saying ‘I think you could look at it now as being negative, but probably it was the best way that it could have happened, because if you look at it for too long, it becomes more daunting.’

The majority of midwife managers and teachers agreed that the philosophy and structure of the programme reflected that expressed during the consultative process by An Bord Altranais (see Figure 5.4). There was a high level of agreement amongst all stakeholders that the programme was balanced in respect of the amount of theory and practice and that the theory and practice content were logical and sequenced (see Table 5.2). Midwives teachers were asked if the breadth and depth of the programme content was relevant to the academic (diploma) level expected. While the majority agreed that the breadth was, 27% (n=4) disagreed that the depth was at diploma level. On further exploration of this during the focus group interview the general view was that if anything the depth was at times ‘too deep’ for diploma level and that the general feeling was that they were teaching at degree level. One said that if the programmes academic status was upgraded to degree status, their teaching depth would have to change little.

![Figure 5.4 The philosophy and structure of the programme reflects that expressed during the consultative process by An Bord Altranais](image)
While the majority agreed that there was adequate time to address the concerns and fears of midwives with regard to their role in teaching, supervising and assessing ‘direct entry’ midwifery students (see Figure 5.5), midwives and managers were less likely than teachers to agree that the time was adequate. The majority also agreed that midwives were adequately prepared to teach and assess these students (see Figure 5.6). However, midwife managers and teachers were more likely than midwives to agree that there had been adequate preparation of midwives.
Figure 5.5 There was adequate time to address the concerns and fears of midwives in practice areas with regard to their role in teaching, supervising and assessing 'direct entry' midwifery students (n=141)

Figure 5.6 There was adequate preparation of midwives in practice placements with regard to the teaching and assessing of 'direct entry' midwifery students (n=141)
Table 5.3 details the preparedness of midwives and midwife teachers to teach and assess ‘direct entry’ midwifery students with 32% (n=36) disagreeing that they were adequately prepared. This did not affect their confidence in their ability to teach and assess students.

<table>
<thead>
<tr>
<th>Table 5.3 Midwives and midwife teachers preparedness and confidence to teach ‘direct entry’ midwifery students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>I had adequate preparation to prepare me to teach</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>I had adequate preparation to prepare me to assess</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>I felt confident in my ability to teach</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>I felt confident in my ability to assess</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

The majority of key stakeholders (n=120; 77%) agreed that the overall aims and objectives of the programme were clear to them with 14% (n=22) disagreeing. The majority also disagreed that the ongoing development of the curriculum was very unsettling. However, the majority of ‘direct entry’ midwifery students found it very unsettling (n=8; 53%). The students in the focus group said that they had received "the big plan" at the start of the programme but that there were then a lot of changes as the programme progressed. One mature student said that she ‘felt quite powerless as a student’ in that, even though small things that could be changed were changed in response to their suggestions, a lot of their difficulties could only lead into benefits for the next group of students, not themselves.

5.9 Conclusion

Ensuring that everyone felt involved in the development of the pilot programme was a stated aspiration of the process and this was achieved to some extent. However the short lead in time would appear to have had an impact on how informed and involved individuals felt in the programme. As already
discussed, in the focus group interviews participants were more likely to say there was consultation and information giving sessions but that it was difficult to ensure that everyone participated. Getting to meetings given the business of the environment was difficult and one suggestion was for written information to be circulated to everyone.

5.9.1 Recommendations

- An adequate lead in period adequate information sharing and consultation, curriculum development, and preparation of those involved in the delivery of the programme;
- Consider developing a newsletter to maintain involvement and information sharing;
- Ensure that all groups directly or indirectly involved, have adequate representation on committees; that there is a mechanism for representatives to share information and decisions and to seek views; and for individuals to make representation.
6.1 Introduction

This chapter details the evaluation of the delivery of the curriculum. The findings of the evaluation presented here are from the questionnaires completed by and the focus group held with the key stakeholders – ‘direct entry’ midwifery students, postgraduate diploma midwifery students, midwives, midwife teachers and midwife managers – during June and July 2003, following the completion of the programme at the end of May 2003. The curriculum as delivered is first outlined. The findings from the evaluation are then presented: the structure, process and outcomes of the delivery of the curriculum. Finally, the main pertinent findings drawn from the chapter are discussed.

6.2 The curriculum

The structure of the three years of the programme is detailed in Appendix I. The programme commenced on the 1st June 2000 with a cohort of twenty ‘direct entry’ midwifery students. With the aspiration to introduce the student to midwifery practice early in the programme, a number of initiatives were put in place. Students spent the first 11 weeks (inclusive of 2 weeks holidays) mainly in a classroom environment, with some exposure to midwifery practice. During week one students visited the practice areas in both maternity hospitals to meet the staff and women and their families. From week three to week eleven the students spent one day per week in the practice environment under the direct supervision of midwife teachers. The focus of the theoretical input provided students with the knowledge, skills and attitudes to maintain the physical and psychological safety of women (and their babies) and of themselves. From weeks twelve to twenty nine the midwifery students experienced an intensive period of preceptored practice with supernumerary preceptors. Following this period (the latter third of year one) the theoretical input was increased to three days per week with two days in the practice environment. Students now shared lectures on the science subjects with nursing students.
During the first half of year two, students undertook further midwifery practice placements. Approximately two thirds of the students had experienced midwifery practice in both of the two linked maternity hospitals by this time. The focus of the theoretical input, supported by practice experience, helped the students to understand the boundaries of midwifery and obstetric practices. Students were also expected to become confident in recognising reproductive, maternal and fetal physiological patterns of progression so that deviations from these were promptly recognised and reported, and appropriate decisions were implemented. This was further facilitated by placements undertaken external to the two linked maternity hospitals during year two, and in particular in the second half of the year. These included placements in medical/surgical, community midwifery, community (psychiatry, women's refuge, drug liaison midwife), paediatrics and an elective placement. Greater detail on the external placements and their evaluation is provided in chapter 8. Both the theory and practice components of year two focused on the midwifery students gaining knowledge of the wider context in which midwifery care in Ireland is placed.

In year three, midwifery students were rostered for thirty-six weeks of the year (inclusive of annual leave) within the two maternity units. Placements of five weeks duration were undertaken in antenatal, intranatal, postnatal, neonatal and gynaecological/operating theatre areas. The theoretical input focused on further developing the midwifery students' skills of reviewing, critiquing and analysing practice, research and evidence and, with practice, on developing decision making skills based upon acquired deep theory and practice knowledge. By the end of the programme, all midwifery students had experienced practice in both of the linked health care institutions.

6.3 Evaluation of the structures for the delivery of the curriculum

Our Lady of Lourdes, Louth/Meath Hospital Group, NEHB, Drogheda, The Rotunda Hospital, and The University of Dublin Trinity College delivered the programme jointly and this collaborative arrangement is detailed in the Memorandum of Understanding signed by the three partners. Midwife teachers and lecturers from the three institutions were facilitated to engage in teaching, assessing and updating their practice skills in both maternity hospitals. It was agreed that The Rotunda Hospital would be the principal site for classroom teaching and learning and, where appropriate, Our Lady of Lourdes, Drogheda. Funding had been made available to The Rotunda Hospital through the ERHA for the
refurbishment of the School of Midwifery, resulting in quality teaching facilities. As midwifery practice and care was seen to be different in both maternity hospitals, midwifery students would undertake midwifery practice placements in both sites, spending approximately two thirds of their time in The Rotunda Hospital and one third in Our Lady of Lourdes.

A number of structures were put in place for the delivery of the curriculum. Resources have been divided into financial, human and physical (see section 5.5 for details). The majority of midwives, managers and teachers agreed that ‘the set up financial resources made available by the Department of Health and Children were adequate’. However between 30-40% of each group selected the ‘not applicable’ category. When this response was further explored in the focus group interviews with teachers, they felt that insufficient funds had been made available, especially in relation to establishing practice skills laboratories. Table 6.1 details midwife managers’ and teachers’ views regarding the adequacy of classroom, personnel and library resources. Although overall, there was majority agreement that these resources were adequate, they were less likely to agree that teaching personnel and library facilities were adequate.

Table 6.1 Midwife managers’ and teachers’ views of the adequacy of teaching facilities, personnel and library resources

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate provision was made by the DOH&amp;C for the development of teaching facilities</td>
<td>N</td>
<td>0</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>0%</td>
<td>5%</td>
<td>68%</td>
<td>5%</td>
<td>18%</td>
<td>5%</td>
</tr>
<tr>
<td>The additional allocation of midwife teachers was adequate</td>
<td>N</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>14%</td>
<td>14%</td>
<td>41%</td>
<td>23%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>The library facilities in TCD and the linked hospitals were adequate for the students’ needs</td>
<td>N</td>
<td>3</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>14%</td>
<td>9%</td>
<td>46%</td>
<td>23%</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

‘Direct entry’ midwifery students, managers and teachers all agreed (n=37; 100%) that classroom facilities in the Schools of Midwifery provided a suitable learning environment. With regard to the
sufficiency of computer/IT facilities to meet students’ needs, the majority of students and teachers agreed (n=22; 73%) that they were, with teachers more likely to disagree (n=6; 20%). Midwives and teachers agreed that there were sufficient resources (library, IT, practice room, midwifery texts etc.) to facilitate their teaching of ‘direct entry’ midwifery students.

Some aspects of the content of the programme were delivered on Trinity College campuses both in College Green and in the Trinity Centre for Health Sciences, St. James’s Hospital. However, as midwife teachers are based in Schools of Midwifery in both linked maternity hospitals, the majority of the classroom content was delivered in these schools, mainly in The Rotunda Hospital. The Schools of Midwifery are both within a short walk of the practice areas. Table 6.2 details the level of agreement/disagreement that this proximity facilitated relationships and approaches to teaching and assessing.

**Table 6.2 Proximity of midwifery practice placements: views of midwives, midwife teachers and managers**

<table>
<thead>
<tr>
<th>Proximity of midwifery practice placements facilitated some of the unique approaches to teaching on this pilot programme</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
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<tr>
<td>N</td>
<td>1</td>
<td>16</td>
<td>75</td>
<td>21</td>
<td>18</td>
<td>10</td>
<td>141</td>
</tr>
<tr>
<td>%</td>
<td>1%</td>
<td>11%</td>
<td>53%</td>
<td>15%</td>
<td>13%</td>
<td>7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proximity of midwifery practice placements facilitated some of the unique approaches to assessing on this pilot programme</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>2</td>
<td>12</td>
<td>78</td>
<td>17</td>
<td>19</td>
<td>13</td>
<td>141</td>
</tr>
<tr>
<td>%</td>
<td>1%</td>
<td>9%</td>
<td>55%</td>
<td>12%</td>
<td>13%</td>
<td>9%</td>
<td>100%</td>
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</tbody>
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<thead>
<tr>
<th>Proximity of midwifery practice placements facilitated personal relationships which made the organisation of placements/assessments easier</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>1</td>
<td>15</td>
<td>70</td>
<td>20</td>
<td>21</td>
<td>14</td>
<td>141</td>
</tr>
<tr>
<td>%</td>
<td>1%</td>
<td>11%</td>
<td>50%</td>
<td>14%</td>
<td>15%</td>
<td>10%</td>
<td>100%</td>
</tr>
</tbody>
</table>
In the focus group interviews, whilst the majority of midwife teachers agreed that the closeness of the practice placements facilitated teaching and assessing there was not complete consensus. They highlighted the ease with which one could go to the clinical areas and see the students, support preceptors, meet the students on the corridors etc. and that the converse was true for those in the practice area also. One teacher stated that proximity was not essential to achieve this and that it could be achieved by the allocation of teachers to practice areas for set periods and the provision of facilities in/close by those areas for teachers to use. A comment by midwifery students in relation to another issue appears to value the proximity/availability of midwifery teachers, saying that they would ‘talk to you in corridors, would always ask you how you are’.

6.4 Evaluation of the process of the delivery of the curriculum

6.4.1 Teaching and learning

An outcome for the programme was that midwifery students would be able to take responsibility for their own learning and being self-directed was seen as an important component. Independent learning time to encourage/facilitate this was incorporated into the curriculum. Figure 6.2 illustrates the overwhelming agreement that ‘direct entry’ midwifery students are motivated to a self directed approach to learning. In the focus group interview with midwife teachers, one felt that from her experience with ‘direct entry’ midwifery students in the UK, they are always committed students. They seem to have this inner drive that she could not explain. Others felt that it was the heterogeneity of the group in terms of their age, life experiences etc. that contributed to their motivation. Another said that the philosophy and the ethos underpinning the programme was also a contributor and that the students saw that if they showed interest in their work that they received back double-fold. The students saw how they could direct their learning. Not having come through a nurse-training programme and socialised into, what one teacher saw as a medicalised model of learning was also put forward as a possible reason. Their ‘woman centredness’ was also suggested as an explanation.
Figure 6.? 'Direct entry' midwifery students were motivated to a self-directed approach to learning (n=156)

Figure 6.? There was adequate time allocated to 'direct entry' midwifery students for independent learning during the programme (n=156)
Although the majority of stakeholders agreed that the allocation of independent learning time was adequate, only small majority of ‘direct entry’ midwifery students (n=8, 53%) agreed that it was. When asked in the focus group interview, those present felt that they had, perhaps, been given adequate time but that sometimes it was given at short notice so that they could not utilise it as well. They suggested that it be more structured in future.

Teaching evidence based practice (where available) is a crucial component of any programme for professional practice. Midwife teachers (n=14, 93%) and midwives (n=73, 61%) agreed that they endeavoured to do this, while all ‘direct entry’ midwifery students agreed that classroom teaching was evidence based (No question was asked regarding practice). The students in the focus group stated that they were confidently able to question people about the reasons for their actions or the research basis for them, due to their research input in class.

It is important that all involved have an understanding of what is expected during each year of the programme and it would seem that for the majority (n=102; 64%) of ‘direct entry’ midwifery students, midwives and midwife teachers the aims and learning outcomes for each year of the programme were clear to them. Figure 6.? illustrates that there was majority agreement that ‘direct entry’ midwifery students understood the level of theory and practice expected of them at different stages of the programme.
Figure 6. 'Direct entry' midwifery students, midwives and midwife teachers views of the extent to which 'direct entry' midwifery students understood the level of theory and practice expected of them at different stages of the programme (n=149)

Figure 6. Midwives and midwife teachers level of agreement/disagreement that they understood the level of practice and theory expected of 'direct entry' midwifery students at different stages of the programme (n=134)
It had been hoped that preceptorship would be in place for all practice placements following the period of supernumerary preceptorship. However, in reality, the allocation of a preceptor and preceptorship was only available when the ‘direct entry’ midwifery student completed a ‘continuous assessment of midwifery practice’ for that placement. As already stated preceptorship for midwifery students was a relatively new concept, especially in one of the maternity hospitals. As the Diploma in Midwifery (Direct Entry) programme neared its completion, preceptorship for all midwifery students was being implemented, in particular when completing practice assessments, and in year three of the programme ‘direct entry’ midwifery students had preceptorship for three of the five midwifery placements. Midwives are gradually undertaking ‘Teaching, learning and assessing in midwifery practice’ programmes to facilitate them undertake this role and in future all qualified midwives in the two hospitals will have undertaken this programme.

The level of support, teaching and feedback students received in practice placements was evaluated. While the majority of ‘direct entry’ midwifery students, midwife managers, midwife teachers, and midwives agreed that midwives make an effort to provide appropriate learning experiences for students, midwifery students were more likely to disagree that preceptors (n=4; 29%) and midwives (n=7; 47%) did (‘Preceptors’ in this case refers to all midwives taking on this role, rather than the supernumerary preceptors alone).

The vast majority of midwives (n= 107; 90%) felt that they did, indeed, provide appropriate learning experiences for students. Those who acted as preceptors viewed themselves, and were viewed by the majority (82, 53%), as being clear about their preceptoring role. However, the majority of ‘direct entry’ midwifery students (n=11, 74%) disagreed that they were. Midwives (including those who were preceptors) did not view themselves as too busy to supervise the midwifery practice of ‘direct entry’ midwifery students and provide them with feedback, nor that it made excessive demands on their time. They were more likely to disagree that they had adequate time to teach ‘direct entry’ midwifery students (Tables 6.2). However, the majority of ‘direct entry’ midwifery

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Table 6.2</strong></td>
<td>Time to teach, provide feedback and supervise the practice of ‘direct entry’ midwifery students</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
students agreed that midwives (n=11; 73%) and preceptors (n=10; 67%) were too busy. The students in the focus group felt that there were not enough midwives and the workload was too high for them, the midwives, to spend time teaching them. Their preceptors (those who had spent 18 weeks with them in a supernumerary capacity) were always helpful and continued to teach them and the postgraduate students throughout the three years as much as they could. Other midwives, however, felt under pressure and did not take on the same teaching and support role. The students felt that newly qualified midwives should not be asked to take on a preceptor role.

In contrast, the majority of midwife teachers disagreed that midwives were too busy to supervise/provide feedback, or that it made excessive demands on midwives’ time. In the focus group
interview, midwife teachers put forward a number of factors to explain this perception. The 18-week preceptorship period in year one of the programme had facilitated the development of a culture where supervision and feedback to students became the norm. It became part of daily practice. They further stated that even now, when the practice site is busy, time is set aside by preceptors to work with their allocated students and ensure that they are doing the right activities to meet the competencies that are expected. The actual nature of assessments and the evidence that has to be provided by the students to their preceptors requires time, and this is made available. There is a complete shift where for the first time the midwifery student has become the centre of attention. The supernumerary status given to the preceptors in the initial 18-week period underscored the importance that was being attached to supervision and feedback and this permeated down to all midwifery staff. They were actually pleased to be involved, to be given the opportunity to have their opinions taken into account, and as one teacher said, it was also a professional development opportunity for them, which in turn facilitated the commitment of time that was required of the midwives.

There was general agreement that preceptors were good at assessing the learning needs of ‘direct entry’ midwifery students (see Table 6.?). Midwives (including preceptors) were also viewed as good at helping students relate theory to practice and they stated that they were confident to do this. They also agreed that ‘direct entry’ midwifery students discussed their learning needs with them and that they were able to provide adequate feedback to students on their progress (see Table 6.?).
### Table 6. Views on midwives’ and preceptors’ ability to teach ‘direct entry’ midwifery students

<table>
<thead>
<tr>
<th>Table 6. Views on midwives’ and preceptors’ ability to teach ‘direct entry’ midwifery students</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I / Preceptors were good at assessing and helping ‘direct entry’ midwifery students meet their learning needs</td>
<td>N</td>
<td>1</td>
<td>9</td>
<td>96</td>
<td>22</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>‘Direct entry’ midwifery students discussed their learning needs with me (midwives including preceptors)</td>
<td>N</td>
<td>3</td>
<td>20</td>
<td>74</td>
<td>8</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>I (midwives including preceptors) was confident in my ability to help ‘direct entry’ midwifery students relate theory to practice</td>
<td>N</td>
<td>0</td>
<td>6</td>
<td>82</td>
<td>18</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Preceptors were good at helping ‘direct entry’ midwifery students relate theory to practice</td>
<td>N</td>
<td>1</td>
<td>0</td>
<td>19</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Midwives (other than preceptors) were good at helping ‘direct entry’ midwifery students relate theory to practice</td>
<td>N</td>
<td>0</td>
<td>8</td>
<td>19</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I (midwives including preceptors) was able to provide adequate feedback to ‘direct entry’ midwifery students on their progress</td>
<td>N</td>
<td>1</td>
<td>2</td>
<td>73</td>
<td>8</td>
<td>29</td>
<td>6</td>
</tr>
</tbody>
</table>

The majority of ‘direct entry’ midwifery students (n=12, 80%) agreed that they discussed their learning needs with their personal midwife teacher, while all teachers (n=15, 100%) agreed that students did do so. Students were also more likely to agree (n=9, 60%) that they seldom discussed learning needs with other midwife teachers, whilst a small majority of midwife teachers (n=8, 53%) disagreed with this statement.
Other professionals were also viewed by the majority of ‘direct entry’ midwifery students, midwives and midwife teachers (n=81, 55%) as helping students learn in practice. However, many respondents (n=41, 28%) selected the ‘not applicable’ category or left the question blank.

6. ‘Giving feedback’

Providing feedback on performance, both theory and practice, is an integral part of the learning experience. Table 6. details the level of agreement/disagreement amongst ‘direct entry’ midwifery students, midwives and midwife teachers regarding feedback to students.

Table 6. Feedback

<table>
<thead>
<tr>
<th>Area</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>My personal midwife teacher provided me with adequate feedback on how I was progressing</td>
<td>N</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7%</td>
<td>13%</td>
<td>53%</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Midwife teacher (other than my personal midwife teacher) rarely provided me with helpful feedback</td>
<td>N</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>20%</td>
<td>53%</td>
<td>20%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>I was able to provide adequate feedback on theory for my personal ‘direct entry’ midwifery students</td>
<td>N</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0%</td>
<td>13%</td>
<td>60%</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>I was able to provide adequate feedback on practice for my personal ‘direct entry’ midwifery students</td>
<td>N</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0%</td>
<td>7%</td>
<td>40%</td>
<td>53%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Feedback from practice assessments always highlighted my/their strengths</td>
<td>N</td>
<td>3</td>
<td>18</td>
<td>72</td>
<td>22</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>2%</td>
<td>12%</td>
<td>48%</td>
<td>15%</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Feedback from practice assessments always highlighted areas I/they needed to develop</td>
<td>N</td>
<td>0</td>
<td>10</td>
<td>92</td>
<td>19</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0%</td>
<td>7%</td>
<td>62%</td>
<td>13%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Feedback from theory assessments always highlighted</td>
<td>N</td>
<td>1</td>
<td>0</td>
<td>19</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>30%</td>
<td>12%</td>
<td>78%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Feedback from theory assessments always highlighted areas I/they needed to develop

<table>
<thead>
<tr>
<th>my/their strengths</th>
<th>%</th>
<th>3%</th>
<th>0%</th>
<th>63%</th>
<th>33%</th>
<th>0%</th>
<th>0%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback from theory assessments always highlighted areas I/they needed to develop</td>
<td>N</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>%</td>
<td>0%</td>
<td>0%</td>
<td>73%</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

2='direct entry' midwifery students; 4=midwife teachers; 6='direct entry’ midwifery students, midwives, and teachers; 12='direct entry’ midwifery students and teachers

In general, feedback was viewed as adequate and helpful, identifying strengths and areas for development. When asked to comment on this in the focus group interview, the students said, "the tutors were great". The tutors all identified individual strengths or weaknesses for individual people and tailored their feedback specifically for each person. The feedback was "always done very constructively" with "suggestions made as to how you could improve".

6. Midwife teachers and teaching and learning in practice placements

‘Direct entry’ midwifery students were more likely to agree that midwife teachers other than their personal midwife teacher taught them in practice placements (see Figure 6.2). When this was further explored in the focus group interview with students, they felt that the difference here was just that, whereas they had one personal midwife teacher, there were more teachers who were not their own, so naturally the others would actually end up teaching them more often. Also, they suggested that Principal Tutors should not be allocated personal students as they had insufficient time to spare to see them in the practice areas. The majority of ‘direct entry’ midwifery students agreed that their personal (n=15, 100%) and other (n=13, 87%) midwife teachers were helpful in assisting them to learn in practice.

Midwife teachers did not agree (n=10, 67%) that they had adequate time to teach in practice placements. In the focus group interview, midwife teachers attributed this to a number of factors. Each of the midwife teachers could have up to 50 personal students at any one time as there are other programmes, the Postgraduate Diploma in Midwifery, running concurrently (4 programmes in The Rotunda and 2 in Our Lady of Lourdes). The Diploma in Midwifery (Direct entry) programme was not the sole programme and it also needed to be prepared for and delivered. One midwife teacher said that there were other activities connected with the pilot programme that had to be fulfilled e.g. reviewing curricular changes which may take half a day, attending meetings and so on, activities which took time
but were necessary to the success of the programme. Again, the issue of An Bord Altranais recommended ratio of teachers to students was raised and according to the group members this needs to be re-evaluated in terms of midwifery education today, as it is too low in comparison to international standards.

There was a high level of agreement as to the availability of midwife teachers to provide support for midwives/preceptors when they were teaching and assessing ‘direct entry’ midwifery students (see Figure 6.?)

![Figure 6.](image-url)
6. Midwifery practice

There was a high level of agreement amongst midwives, midwife managers and teachers (n=115, 82%) that ‘direct entry’ midwifery students were content most of the time in practice placements. This question was asked of ‘direct entry midwifery students regarding each placement rather than a general statement about practice placements as a whole. These findings are not reported here but overall the majority of students were content in each placement area with the exception of one area where equal numbers agreed as disagreed. Managers were more likely to agree (n=6, 93%) that learning outcomes that ‘direct entry’ midwifery students must achieve in practice placements were clear than midwives were (n=73, 61%). All midwife teachers agreed that the learning outcomes were clearly identified for ‘direct entry’ midwifery students and midwives. Again ‘direct entry’ midwifery students were asked specifically about the learning outcomes for each practice area and the majority of students agreed that they were understandable for all placement areas. There was a high level amongst midwives, midwife managers and teachers (n=121, 86%) that learning outcomes for all practice placements were relevant to becoming a midwife. When specifically in relation to each practice placement if the knowledge and skills
they gained was relevant to becoming a midwife, for all placements, there was a high level of agreement amongst ‘direct entry’ midwifery students that it was.

There was also general agreement amongst ‘direct entry’ midwifery students, midwives, and midwife teachers (n=97, 65%) that they were clear about the level of competence in midwifery practice ‘direct entry’ midwifery students must achieve in each year of the programme.

‘Direct entry’ midwifery students were supernumerary to the midwifery team during year one and two of the programme. This is in contrast to the employee status of the Postgraduate Diploma midwifery students, who form an integral part of the midwifery team delivering care during the totality of their two year programme. In year three the status of the ‘direct entry’ midwifery student changes to that of employee for practice placements. The overwhelming majority of midwives, managers, and teachers agreed that the supernumerary status of the ‘direct entry’ midwifery students was understood (see Figure 6.?). In contrast, the majority of students (85% n=11) felt that midwives were unsure of the meaning of their supernumerary status.
However, the students in the focus group felt that this was a problem at the end of first year and in second year only. Many midwives did not know that they were not being paid and were therefore expecting the students to work hard and turn up for duty on busy days rather than when it suited them.

6.4.2 Assessment

An aim of the curriculum is that the assessment of learning contributes to learning and to the development of the midwifery student. A variety of assessment strategies are used and particular attention has been given to the assessment of midwifery practice with the development of the assessment strategies, preceptorship and the documentation.

As illustrated in Figure 6.?, midwives, midwife managers and teachers disagreed that the programme was over assessed in contrast to the majority of ‘direct entry’ midwifery students (n=10, 67%) agreeing that it was. When this was explored during the focus group interview with students, those present found it hard to think of any assessment that they felt could be left out. As one said: "Which one could you drop?" The only two areas that they specified were: one of the two research critiques could be left out,
because "the postgraduate students only do one" (there was, however, only one research critique as an assignment but with two research reports to be critiqued); and some aspects of the continuous practice assessment document could be more specific to the practice area the assessment was in, as they found it quite boring and repetitive by the time they reached year 3.

In the focus group interview with midwife teachers they were asked to consider what assessments might be dropped considering that six (40%) had agreed that the programme was over assessed. However, there was no one in the group who agreed with this statement and therefore would not suggest that any theory or practice assessment was dropped. One teacher wondered if it was because the actual preparation for assessments took considerable time that some believed it was over assessed. Another midwife teacher stated that the array of assessments was excellent and allowed the student who might be weak at writing a three-hour examination paper but good at, perhaps, presenting material to be successful at assessments.

Figure 6. Overall, this programme has been over assessed

![Bar chart showing the percentage of respondents who strongly disagree, disagree, agree, strongly agree, not applicable, and missing their agreement with the statement that the programme is over assessed.](chart)

- **Midwife managers (n=7)**
- **Midwives (n=119)**
- **Midwife teachers (n=15)**
- **"Direct entry" midwifery students (n=15)**
The majority of midwives, midwife managers and teachers disagreed (n=92, 51%) that there was little variety in the way the programme was assessed with twenty-nine (20%) agreeing that there was. A number of midwives either selected the ‘not applicable’ category (n=27, 19%) or left the question blank (n=13, 9%).

Assessment/examinations are times of stress for students and how the assessment is carried out may facilitate or be detrimental to the student’s performance or how they perceived they performed. As illustrated in Figure 6.?, there was majority agreement amongst ‘direct entry’ midwifery students, midwives and midwife teachers that assessments were conducted in an non threatening manner.

The students in the focus group were overwhelmingly appreciative of the way in which they had been put them at their ease at the start of an assessment, and how their positive actions were continually reinforced as the assessment proceeded. If students became anxious or upset they were told to go outside, sit quietly, take a few deep breaths and have a cup of tea before resuming the assessment again.
All but one of the ‘direct entry’ midwifery students (n=14, 93%) and all midwife teachers agreed that students were given detail of assessments in adequate time. The guidelines for assessments were also found to be clear by the majority of midwives (n=71, 60%) and midwife teachers (n=15, 100%).

Midwives and midwife teachers were involved in all assessments of midwifery practice on this programme. Midwifery practice placement in which midwifery students completed a ‘continuous assessment of midwifery practice’ were of 5 weeks duration. It was a tripartite assessment involving the ‘direct entry’ midwifery student’s self assessment of her own practice, and the preceptor/midwife and the personal midwife teacher assessment of the student’s midwifery practice. They meet at three point – beginning, midpoint and endpoint and minimum criteria were set for contact between student and preceptor and student and midwife teacher. There was strong agreement that midwife teachers should be involved in this assessment process (see Figure 6.?). In the focus group interviews, midwives and midwife managers identified the midwife teacher as providing the student with continuity over the three year. As one manager said ‘the tutor is the one constant in terms of the assessment and the development of the student and they are an integral part of the teaching, of the assessment’. The advantages of it being the same midwife teacher meant that they could see progression (or not) development resulting in a more structured assessment. One manager felt that this would probably be more rewarding for the student. They also identified that the teacher can observe if ‘the practical and theory are coming together and they are not just good at one part and not in the other’. They also felt that they linked the theory and the practice. ‘Direct entry’ midwifery students in the focus group also put forward similar reasons and were adamant that midwife teachers should be
Midwife teachers should be involved in the three stages of the continuous assessment assessment (n=156)

- **Strongly disagree**: 1%
- **Disagree**: 3%
- **Agree**: 56%
- **Strongly agree**: 31%
- **Not applicable**: 6%
- **Missing**: 3%

Present for all assessments because they provided continuity, particularly for the continuous assessments where the student was expected to progress from point A to point B over a period of time. Again the point was made that some of the midwives, who had not undertaken the specific education programme to become one of the main preceptors to the students in their first year, were not always willing participants in the process. Also, personality clashes were mentioned and the teacher was thought to provide a third person's presence that was valuable. These problems were only apparent in 2nd and 3rd year, as in 1st year the preceptors were all volunteers who spent 18 weeks with the students.

There was majority agreement amongst key stakeholders that practice assessments accurately tested the development of ‘direct entry’ midwifery students’ midwifery practice (see Figure 6.?). In focus group
interviews, midwives stated that the identification of the level of competency specifically for each year in the assessment documentation meant that they could easily recognise progression and improvement. Reflection by the student on her practice by also highlighted by both managers and midwives as important, as one manager stated ‘they require the student to be reflective and to have identified how they’re learning and give examples and I suppose that gives the assessors the opportunity to assess the accuracy of what the student is saying they have learnt’. ‘Direct entry’ midwifery students identified the qualities of the preceptor as important to this process. One student said: ‘If you had a good preceptor who had time to spend with you it was excellent, they tested you really well and you came out feeling very positive. But if you had someone who was very busy and who didn't want to do it in the first place, God, you could come out feeling worse, like you'd learnt absolutely nothing. You just felt useless’. The episodic assessment of midwifery practice completed each year were described positively by the students in the focus group in that they "started off very basic and then as we progressed from year to year, they became bigger and more challenging." The negative points included the fact that "you could be having a bad day" and therefore not perform as well as usual.

Table 6.? details the responses to a number of questions asked regarding the marking of assessments.
Table 6.? Marking of assessments

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>The marking of assessments accurately tested the development of</td>
<td>N 2</td>
<td>19</td>
<td>72</td>
<td>6</td>
<td>25</td>
<td>10</td>
<td>134</td>
</tr>
<tr>
<td>a midwifery student’s midwifery practice</td>
<td>% 1%</td>
<td>14%</td>
<td>54%</td>
<td>4%</td>
<td>19%</td>
<td>7%</td>
<td>100%</td>
</tr>
<tr>
<td>The marking of assessments accurately tested the development</td>
<td>N 0</td>
<td>0</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>of the academic ability of an individual student</td>
<td>% 0%</td>
<td>0%</td>
<td>87%</td>
<td>13%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>The marking criteria for assessments was easy to use</td>
<td>N 3</td>
<td>16</td>
<td>59</td>
<td>11</td>
<td>36</td>
<td>9</td>
<td>134</td>
</tr>
<tr>
<td>% 2%</td>
<td>12%</td>
<td>44%</td>
<td>8%</td>
<td>27%</td>
<td>7%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Marking of practice assessments varied greatly amongst midwife</td>
<td>N 1</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>2</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>preceptors</td>
<td>% 3%</td>
<td>30%</td>
<td>27%</td>
<td>33%</td>
<td>7%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Marking of practice assessments varied greatly amongst midwife</td>
<td>N 3</td>
<td>20</td>
<td>31</td>
<td>16</td>
<td>49</td>
<td>15</td>
<td>134</td>
</tr>
<tr>
<td>teachers</td>
<td>% 2%</td>
<td>15%</td>
<td>23%</td>
<td>12%</td>
<td>37%</td>
<td>15%</td>
<td>100%</td>
</tr>
<tr>
<td>Marking of theoretical assessments varied greatly</td>
<td>N 3</td>
<td>16</td>
<td>5</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>% 10%</td>
<td>53%</td>
<td>17%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

In all assessments, both theory and practice assessments, a mark is awarded. Midwives and midwife teachers agreed that the marking of assessments accurately tested the development the ‘direct entry’ midwifery student’s midwifery practice with all teachers agreed that this was also the case for the student’s academic ability. Marking criteria needs to be easy to use and the majority of midwives and midwife teachers agreed that they were. All but one ‘direct entry’ midwifery students (n=14, 93%) agreed that the marking of practice assessments varied greatly amongst preceptors and also amongst midwife teachers. In the focus group interview students stated that a number of midwife teachers and preceptors were well known to the mark more stringently than their colleagues and the students in the focus group felt very strongly about this. As one student said: "If 'exceptional' is in the book, it's there for a reason, and to be told at the outset 'I don't give exceptional' - then why was it there?"
Midwife teachers were more likely to agree (83% n=5) that ‘direct entry’ midwifery students are given details of assessments in adequate time then the students themselves were (62% n=8 agree vs. 38% n=5 disagree). Almost all the midwife teachers agreed that they should be involved in the three stages of the continuous practice assessment on this programme.

All midwife managers and teachers agreed that practice staff facilitated the assessment of ‘direct entry’ midwifery students. While all midwife managers agreed that the needs of midwives and the ward activity was taken into account by the course co-ordinators and midwife teachers when organising assessments, only 41% (n=48) of midwives agreed that they did with 40% (n=47) disagreeing. Twenty percent (n=14) selected the ‘not applicable’ category or left the question blank.

Seventy one percent (n=32) of midwives agreed that they were able to motivate students to work to their maximum potential. The majority of midwifery students (77% n=10) agreed that they were motivated to work to their full potential by midwife teachers.

Midwifery students unanimously agreed/strongly agreed that they were encouraged to participate in class.

Midwife teachers all (n=6) agreed that it was important that they individually be given responsibility for aspects of the programme. The curriculum model is composed of themes and sub-themes and it was envisaged a midwife teacher would take responsibility for at least one sub-theme. However in practice this has not been achieved. When asked if ‘my role as a sub-theme leader is clear to me’ only 50% (n=3) of midwife teachers agreed with 33% (n=2) disagreeing and 17% (n=1) selecting the ‘no response’ category.

6.5 Outcomes of the delivery of the curriculum

The over-whelming majority of ‘direct entry’ midwifery students, midwives, midwife managers and teachers agreed, with many strongly agreeing, that being part of this pilot programme was exciting (see Figure 6.?).
Figure 6.? Being part of this pilot programme of 'direct entry' to midwifery was exciting (n=156)

There was a high level of agreement that the overall structure of the programme was satisfactory with all ‘direct entry’ midwifery students, midwife managers and teachers agreeing that it was (see Table 6.? and Appendix ? for the structure of the programme). The allocation of annual leave was also viewed as adequate by the majority. As already described in the curricular model (see 5.7), the integration of theory and practice was a key principle. There was a high level of agreement that this was achieved with the balance of theory and practice enabling the outcomes for the programme to be met (see table 6.?).

The overwhelming majority of key stakeholders agreed, with almost half strongly agreeing, that the early experience of midwifery practice (with midwife teachers from week 3 and supernumerary preceptors from week 12) was a strength of this pilot programme (see Figure 6.). In the focus group interviews with managers, they stated that it introduced the students to the ‘reality very quickly’ but that it was ‘gradual as well, which was good’. One said that from the midwives point of view it was good to see the ‘direct entry’ midwifery students on the wards early. Midwives made similar comments. They also commented on the knowledge the students had with one saying ‘By the time they came out on the ward after the 18 weeks they had a huge knowledge’.

Table 6.? The structure of the programme

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall structure of the programme (i.e. the timetabling of theory, practice, annual leave) has been satisfactory</td>
<td>N 3</td>
<td>10</td>
<td>91</td>
<td>18</td>
<td>27</td>
<td>7</td>
<td>156^5</td>
</tr>
<tr>
<td>%</td>
<td>2%</td>
<td>6%</td>
<td>58%</td>
<td>12%</td>
<td>17%</td>
<td>5%</td>
<td>100%</td>
</tr>
<tr>
<td>Given the requirements of the programme must meet, the amount of annual leave allocated in each year was adequate</td>
<td>N 0</td>
<td>11</td>
<td>81</td>
<td>11</td>
<td>39</td>
<td>14</td>
<td>156^5</td>
</tr>
<tr>
<td>%</td>
<td>0%</td>
<td>7%</td>
<td>52%</td>
<td>7%</td>
<td>25%</td>
<td>9%</td>
<td>100%</td>
</tr>
<tr>
<td>Theory and practice were not integrated in a meaningful way</td>
<td>N 26</td>
<td>85</td>
<td>21</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>156^5</td>
</tr>
<tr>
<td>%</td>
<td>17%</td>
<td>54%</td>
<td>13%</td>
<td>3%</td>
<td>7%</td>
<td>5%</td>
<td>100%</td>
</tr>
<tr>
<td>The balance of theory and practice enabled the outcomes of the programme to be met</td>
<td>N 1</td>
<td>15</td>
<td>90</td>
<td>25</td>
<td>19</td>
<td>6</td>
<td>156^5</td>
</tr>
<tr>
<td>%</td>
<td>1%</td>
<td>10%</td>
<td>58%</td>
<td>16%</td>
<td>12%</td>
<td>4%</td>
<td>100%</td>
</tr>
<tr>
<td>The theoretical input at the beginning of the programme was adequate</td>
<td>N 0</td>
<td>10</td>
<td>92</td>
<td>16</td>
<td>30</td>
<td>8</td>
<td>156^5</td>
</tr>
<tr>
<td>%</td>
<td>0%</td>
<td>6%</td>
<td>59%</td>
<td>10%</td>
<td>19%</td>
<td>5%</td>
<td>100%</td>
</tr>
</tbody>
</table>

^5 = ‘direct entry’ midwifery students, midwives, managers and teachers

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**Figure 6.** In year one, an early experience of midwifery practice was a strength of this pilot programme (n=156)
6.5.1 Location of the programme

As already stated, the programme was delivered as a partnership between the School of Nursing and Midwifery Studies, Trinity College, Our Lady of Lourdes, Drogheda and The Rotunda Hospital. The ‘direct entry’ midwifery students were students of TCD. The Rotunda Hospital was the main site for the delivery of the classroom content, although facilities in TCD were also used occasionally, and midwifery practice was undertaken in both maternity hospitals. While the majority of midwives, midwife managers and midwife teachers agreed (n=92, 65%) that ‘being midwifery students of the University of Dublin TCD enhanced the education of ‘direct entry’ midwifery students, the students themselves agreed (n=14, 93%) that they did not feel that they were university students. From the focus group interview, it would appear that they equated TCD’s College Green campus with the identity of a TCD student. The students in the focus group said that they had "only visited Trinity 2 or 3 times", as the lectures were all in the maternity hospitals or the Trinity Centre at St. James's campus. They had all used the library, but it tended, again, to be the TCD health sciences library at St. James's campus, rather than any on the main TCD campus. One comment was that ‘we hadn't time to go near the place’, because of their clinical placements in addition to all their theoretical work.

There was over-whelming agreement amongst ‘direct entry’ midwifery students, midwives, midwife managers and midwife teachers (n=130, 83%) that, although it was sometimes difficult, there were benefits for ‘direct entry’ midwifery students experiencing midwifery practice in both hospitals. In the focus group interviews, the students present were, on the whole, in agreement that the benefits outweighed the disadvantages of attending both hospitals. One said that even though it was difficult for her to get to hospital X, it opened up a whole new world, gave a much broader experience, with different types of clientele and different birth positions being used. Others said that it was different midwives that showed you different positions, not being in a different hospital, per se and that it depended on the workload whether or not you would see different things in your 'second' hospital. In the focus group interview with teachers, they put forward that experiencing different models of care could occur on one site depending on the institution or may require multiple sites. One teacher said that it was unlikely if the students would have experienced the variety of models of care that they did in maternity hospital if they had been practiced in two of the Dublin maternity hospitals, as their mode of acre is quite similar. Midwife managers and teachers also identified the travel and accommodation difficulties students encountered and stated that this would need to be reviewed in the development of
future programmes and the resource implications from the students’ perspective had to be considered. In the focus group interviews with midwives, whilst the midwives present also identified the aforementioned benefits, there was not a complete consensus. Some midwives identified the difficulty it posed in tracking a student’s progress, for example, was she achieving the number of birth she was required to facilitate and the confusion it caused the student regarding different policies in both hospitals. Other saw this as a benefit, exposing them to more than one way of doing it. One midwife’s comment reiterated that made by the students saying ‘it was good that there was definitely different cultures in maternity care in ... and maternity care here’. Another commented that an experience in community midwifery as well as hospital would ‘really give them two different cultures’.

Whilst there was majority agreement that experiencing midwifery practice in two maternity hospitals helped ‘direct entry’ midwifery students transfer midwifery skills from one setting to another, the majority of students (n=10, 67%) disagreed that it did (see Figure 6.?)
The students in the focus group were vociferous in stating that transfer of skills was hampered, not assisted, by experiencing midwifery care in two different hospitals, because of the differing ways of performing even simple procedures (a point also made by some midwives). The tasks mentioned as causing the most difficulty were: the paper-work, the layout, putting up drips and setting up for an epidural. One said: ‘It was a nightmare trying to learn the different ways and you’d really get your wrist slapped for doing something the 'wrong' way’. Another agreed, adding: ‘And it would be nothing life-threatening at all, it would be something stupid. 'Oh, we don't do that like this here!', you know, but it would seem you'd committed a mortal sin’.

When asked if ‘direct entry’ midwifery students identified with one maternity hospital than the other, there was a high level of agreement amongst the students (n=13, 86%) that they did, with the majority of midwives (n=58, 49%) and midwife managers (n=3, 43%) also agreeing, but a small majority of midwife teachers (n=8, 53%) disagreeing that they did. From the focus group interview with students, it would appear that how accepted they felt they were influenced if they identified with that maternity hospital. Both managers and teachers in the focus group interviews disagreed that they identified with one institution more than another. One manager said ‘I think they just saw themselves affiliated to both, with the midwifery’. Midwife teachers believed that what seemed important to the students was what they could learn from being in that particular place which would contribute to their overall midwifery training. A specific site or identification with it was not considered important but actual facilitating the midwifery students’ experience of different models of care was the key.

6.5.2 Competent midwives at the point of registration

6.2.3.1 Midwifery practice

A small majority of students (54% n=7) disagreed that they had adequate opportunity during the programme to develop their midwifery practice whilst the majority of midwives (76% n=34), midwife
teachers (83% n=5) and managers (100% n=4) agreed/strongly agreed that midwifery students had adequate opportunity.

Only 38% (n=5) of midwifery students agreed that ‘all practice placements have so far been relevant on this programme’ with (62% n=8) disagreeing (31% n=4 strongly). This is in contrast to 78% (n=35) of midwives agreeing with this statement.

The majority of midwives and midwifery students agreed/strongly agreed (67% n=30 and 62% n=8) that midwifery students had had sufficient practice experience so far in the programme to practice to the level of competency required of them. Again 20% (n=9) of midwives selected the ‘no response’ category. There was high agreement amongst midwives, midwife teachers and midwifery students that the theoretical input had been sufficient to enable students to practice to the level required of them. One midwife teacher (17% n=1) and 12 (27%) midwives selected the ‘no response’ category. As illustrated in Figure 9, 38% (n=17) of midwives and 46% (n=6) of midwifery students agreed/strongly agreed that there were areas of midwifery practice that students were inadequately prepared to practice to the level of competence expected at this point in the programme. However whilst less midwives (31% n=14) than midwifery students (54% n=7) disagreed/strongly disagreed, 31% (n=14) of midwives selected the ‘no response’ category.

When asked their level of agreement/disagreement with the statement, ‘Direct entry’ midwifery students have little opportunity to put theory into practice on this programme’ the majority of midwifery students (69% n=9) and midwives (62% n=28) disagreed with this statement. All midwife teachers (n=6) and 75% n=3) of managers (25% n=1 selected the ‘no response’ category) agreed/strongly agreed that ‘direct entry’ midwifery students were able to apply theory to practice.

Midwives and Postgraduate Diploma midwifery students were asked their level of agreement/disagreement with the statement ‘At this point in the programme ‘direct entry’ midwifery students have the potential to be competent midwives at the point of registration’. Eighty five percent (n=63) of PGDip midwifery students and 78% (n=35) of midwives agreed/strongly agreed with this
statement with 7% (n=5) of students and 4% (n=2) of midwives disagreeing. Eight percent of students (n=6) and 18% (n=8) of midwives selected the ‘no response’ category.

The following figure (10) illustrates the strong agreement that practice in two maternity hospitals had benefits. For the majority of students (62% n=8) experiencing practice in two maternity hospitals has helped them to transfer skills from one setting to another, with 31% (n=4) disagreeing that it helped.

**Figure 10:** ‘At this point I can see the benefits of ‘direct entry’ midwifery students experiencing practice in two maternity hospitals’

6.2.3.2 Outcomes for year one of the programme

All midwife teachers, managers and midwifery students described the overall level of competence achieved for 11 outcomes by the majority of midwifery students for year one, whilst between 22 - 27% of midwives selected the ‘no response’ category for each outcome (Appendix?). Midwives were also likely to state that the required level of competence had not been met as opposed to no midwife manager or midwifery student stating this. One (17%) midwife teacher identified that the majority of students had not met the required level with regard to one outcome ‘recognise the limitations of their own practice and knowledge’. Midwifery students were much more likely then midwifery teachers, managers and midwives to state that the majority of midwifery students had reached competency levels
above or at an exceptional level. Some midwives and midwife teachers identified that the majority of students had reached exceptional level of competence in 5 out of the 11 outcomes with no midwife manager identifying students at this level. Appendix I provides detailed tables to illustrate the responses.

The majority of midwives (51% n=23), midwife managers (75% n=4), midwife teachers (83% n=5) and midwifery students (100% n=13) agreed/strongly agreed that the balance of theory and practice enabled the outcomes for year one to be met. Forty percent (n= 18) of midwives and 25% (n=1) of managers selected to ‘no response’ category for this statement.

6.2.3.3 Postgraduate Diploma Midwifery Students

Postgraduate Diploma midwifery students were asked a number of questions about the programme and practising with ‘direct entry’ midwifery students. The majority of students disagreed (64% n=47) that they had been given adequate information about the programme. When asked their level of agreement/disagreement with the statement ‘I strongly believe you do need to be a registered general nurse before becoming a midwife’, a small majority (54% n=40) disagreed with this statement with 43% (n=32) agreeing. Interestingly very few selected the strongly agree (5% n=4)/disagree (4% n=3) categories. When asked if they noticed the lack of nursing skills of ‘direct entry’ midwifery students 50% (n=37) agreed that they did while 38% (n=28) disagreed. Eighty two percent (n=60) of students stated that they enjoyed practising with ‘direct entry’ midwifery students with only 8% (n=6) disagreeing. They were unsure whether ‘direct entry’ midwives were in practice in Ireland at that time (46% n=34 agreeing and 31% n=23 disagreeing) and also if they were practising in their hospital (37% n=27 agreeing and 37% n=30 disagreeing). A significant minority selected the ‘no response’ category to both statements.

Postgraduate Diploma midwifery students were asked if a ‘direct entry’ to midwifery programme had been available before they started nursing would they have chosen that route into midwifery. The majority (72% n=53) said ‘no’, 10% (n=7) said ‘yes’ with 18% (n=13) saying they were unsure. This is potentially 28% (n=20) of this cohort of Postgraduate Diploma midwifery students that might have considered ‘direct entry’ to midwifery if available.

6.2.3.4 Involvement in the programme
All midwife teachers and 69% (n=31) of midwives agreed that they were encouraged to be involved in the programme. All midwife teachers agreed/strongly agreed that communication with the course co-ordinator was adequate. Fifty six percent (n=25) of midwives agreed that the structures to communicate with the course co-ordinator were adequate with a significant minority selecting the ‘no response’ category possibly indicating that they were not aware of these. Almost equal percentages of midwives agreed (47% n=21) and disagreed (44% n=20) that they had ‘received sufficient information and support to enable them to support ‘direct entry’ midwifery students. All midwifery students agreed that they had been informed of the structures that provided support and guidance.

6.2.3.5 Midwifery as a career choice

The vast majority of students (85% n=11)) stated that the decision to pursue a career in midwifery was right for them. Two (15%) students selected the ‘no response’ category. Figure 11 illustrates the level of agreement/disagreement as to whether midwifery students were more committed to becoming a midwife than they were at the beginning of the programme. Midwife teachers were more likely to agree/strongly agree. This question may be ambiguous in that if students were perceived to be very committed at the beginning of the programme then it may be difficult to identify if they are more committed or not at this point in the programme.

Midwifery students totally agreed that their previous work experience had helped them on this programme whereas 56% (n=25) of midwives, 67% (n=4) of midwife teachers and 50% (n=2) of managers agreed it was of help. In relation to life experience midwives were the least likely to agree that this was needed (58% n=26) whilst the majority of midwifery students (77% n=10) teachers (83% n=5) and managers (75% n=3) agreed it was of benefit.

Figure 11 ‘At this point in the programme ‘direct entry’ midwifery students appear more committed to being a midwife than at the start of the programme’
Eighty five percent (n=11) of the midwifery students agreed/strongly agreed that they were enjoying the programme with 8% (n=1) each disagreeing and strongly disagreeing.

There was majority agreement amongst midwives and postgraduate midwifery students that at this point in the pilot programme, direct entry to midwifery will become a route into midwifery (Figure 12). This question was not asked of managers or teachers at this time. When asked if they would be happy to have a ‘direct entry’ midwife as part of the team again the majority of midwives (92% n=41) and postgraduate midwifery students (92% n= 68) agreed/ strongly agreed.

**Figure 12** ‘At this point in the pilot programme I believe ‘direct entry’ to midwifery will become a route into the midwifery profession’
6.3 Discussion and conclusion

A number of the issues that require further explanation and/or exploration are discussed in this section and a number of recommendations are put forward for consideration with regard to the final evaluation and the development of future programmes. The involvement of all key stakeholders would be considered to be paramount to the success of any venture. As already alluded to, this was and is a guiding principle in the development and delivery of this programme. The degree however to which this has been achieved is doubtful given that a large minority of midwives, midwifery students – both ‘direct entry’ and PG Diploma, and managers disagreed that they had a ‘voice’ in the development of the programme. This may be further illustrated by low response rates (midwives 22% n=45, managers 50% n=4) and the significant percentage of midwives who selected the ‘no response’ category in response to many question especially when asked their views about aspects of the programme. While all agreed that they had representation on the key committees, this did not manifest itself in individuals perceiving they had a voice or were kept abreast of developments. Two possible factors are put forward for consideration as to why this may have happened. The first factor to consider is the short lead in time in which to develop and start the programme. One meeting with midwives was held in both linked maternity hospitals to provide information and discuss the implementation of the programme. It had been envisaged that these meeting would continue on an ongoing basis. In reality, meeting with midwives take place when there is a specific information need to be addressed in relation to assessments and practice placements. In the development of future programme, consideration should be given to
delegating this function to perhaps other member of the curriculum development committee, possibly putting in place specific structures, in this case setting up meetings, where representatives would provide information and discuss the development and delivery of the programme. However cognisance must be taken as to the pressure all key stakeholders were under in delivering essential midwifery care to women and their babies. The second factor to be considered leads on from the previous point and relates to what structures are in place to ensure that those elected/selected to represent a group communicate with that group, seeking and representing their views.

Midwifery students disagreed with midwives – practitioners, managers and teachers – with regard to a number of issues: supernumerary status, sufficient allocation of ‘independent learning’, over assessment, relevance of all learning outcomes to becoming a midwife, and practice in two settings. This is the first group of midwifery students to have supernumerary status whilst on practice placements for the first two year of the programme. A lack of understanding of this status began to emerge following the preceptorship period of practice, from week 12 – 29. Students were now in practice placements without supernumerary preceptors and although it was envisaged that each student would be allocated a named midwife to act as preceptor for all practice placements this in reality did not happen for the remainder of year one. Also students were in placements for a maximum of 2 days per week during this time. Student representatives brought this issue to the attention of the Course Co-ordinator and to both the Curriculum Development Committee (23rd August 2001) and Direct Entry to Midwifery Committee (6th September 2001) and midwife managers and teachers undertook to discuss this with midwives in the practice areas. As to how successful this was is hard to comment on as, at this time, half the students began a one month medical/surgical placement and the other half undertook a midwifery practice placement during which they completed a continuous assessment of midwifery practice. For the purposes of the completion of this assessment each student was allocated a named preceptor and practised closely with this person. The issue was not raised again at the meetings of both Committees. The final evaluation will revisit this issue and may find that the changes put in place had the desired effect.

The allocation of ‘independent learning’ time was not considered adequate by students. This is further reflected in a finding of the evaluation of external placements where students unanimously agreed that the allocation of a day per week to independent learning facilitated them to ‘learn/study/explore’
placement related issues. From this interim evaluation the importance of this time to students is highlighted and it ‘fits’ with the philosophical perspective of adult learning. In future programmes this needs to be considered taking cognisance that there are national and international standards with regard to the number of hours allocated to the theory and practice within programme (given that the number of contact/teacher directed hours are not specified). Factors relating to students’ different learning styles also need to be explored.

Midwifery students perceived the programme to be over assessed so far. In an attempt to place this in context, in her end of year report, the external examiner commented that the programme had half the amount of assessment of similar programmes in Scotland. This comment was not a criticism but acknowledged the high achievement of the students and their ability to integrate research/evidence into their assignment. At the point of the completion of this interim evaluation and since June 2001, students had completed 3 academic pieces of work, 2 2-hour examinations and a continues practice assessment and were about to undertake further theory and practice examinations. Three of these assessments concerned the sciences – biology x 2 2-hour examinations, sociology x 1500 word essay and psychology x 1500 word essay and although the content was delivered in year one it was not completed in time to allow for its assessment in that year. It is important that assessment is seen as an important learning tool and not just as a check of students’ knowledge of the content. In a future programme alternative methods of assessment should be considered. Whether some of the assessment strategies were repetitive in relation to the expected learning (i.e. development of library, literature searching/retrieval, academic writing skills) needs to be considered.

Students disagreed with other key stakeholders with regard to a number of aspects of their experience of midwifery practice. A large minority of midwifery students did not feel that the learning outcomes identified for practice placements were relevant to becoming a midwife. The interim evaluation does not provide any further insight into the learning outcomes that were viewed as not relevant or the reasons why. A small majority of midwifery students disagreed that they had adequate opportunity in the programme (so far) to develop their midwifery skills and only a minority agreed that all practice placements were relevant. Could this reflect the timing of the completion of this interim evaluation by the students? Four weeks had been spent in a medical/surgical placement, which anecdotally many did not perceive as relevant, and also that this placement had taken them away from midwifery practice. An
evaluation undertaken of this placement is not available at this time. All had agreed that they had had sufficient practice to enable them achieve the level of competence expected for this stage of the programme and this would have been confirmed by the completion of a continuous assessment of midwifery practice with all students reaching the acceptable standard expected and many achieving an above/exceptional standard. A significant minority of students felt that practice in two setting was not helpful in skills transfer. This needs to be explored further to elicit why is does not help and if it may actually hinder skills acquisition.

All participants positively viewed the integration and balance of theory and practice and an early experience of midwifery practice was seen as a strength of the programme. This endorses the curricular model that sought to avoid the separation of theory and practice and the frontloading of the programme with theory. The teaching, learning and assessing was also on the whole viewed positively. Whilst midwife managers and teachers disagreed that there was adequate time to prepare midwifes for their role in teaching and assessing ‘direct entry’ midwifery students, midwives themselves did not share this view to the same extent. Midwives were found to provide adequate learning opportunities for students and were able to help students relate theory to practice. Midwives who acted as preceptors were also described as good at assessing and helping students meet their learning needs. On the whole at the time of the interim evaluation key stakeholders held positive views regarding the outcome of the pilot programme. Midwives and PGDip midwifery students viewed ‘direct entry’ midwifery students as displaying the potential to become competent midwives and that ‘direct entry to midwifery’ would become route into midwifery. The majority of ‘direct entry’ midwifery students considered midwifery the right career choice for them and described themselves as enjoying the programme.

6.5.1 Recommendations

Final evaluation

- Use focus group interviews/ interviews to explore issues that emerge during the quantitative data collection stage;
- Explore the adequacy of the structures put in place to develop and deliver the programme;
- Explore the relevance of all practice placements to ‘becoming a midwife’;
• Explore the benefits of practice experience in the two linked maternity units and the aspects that were perceived as a possible hindrance to skill transfer.

Further programmes

• Review the structures and processes of communication to ensure that all key stakeholders have the means to keep abreast of the development of the programme and have a forum to voice an opinion(s);
• Consider an increase in the amount of time allocated to ‘independent learning’;
• Review the assessment strategy in year two of the programme;
• The concept of midwifery students as supernumerary should be reviewed and consideration given to the inclusion of independent learning time (especially in year one of the programme) in order to maximise learning while in practice placements.
Chapter Seven

Supernumerary preceptorship

7.1 Introduction

This chapter details the development and evaluation of preceptorship for the Diploma in Midwifery (Direct Entry) Programme. The model of preceptorship described herein began to emerge during the initial conception of the direct entry to midwifery programme and the consultation process engaged in by An Bord Altranais with the midwifery profession. It was agreed that the direct entry midwifery student would require additional support in practice to facilitate the acquisition and development of appropriate knowledge and skills. There were a number of factors that emerged from discussions with the profession, which contributed to the model of support, and were subsequently implemented. Firstly, the concept of preceptorship/mentorship for all midwifery students has long been an aspiration of all involved in midwifery education; however, its achievement has not been fully realised. Midwifery students who are registered general nurses have employee status, are salaried during the two years of their midwifery programme, and are an integral part of the delivery of maternity services. By the end of the pilot programme, preceptorship had been introduced for these midwifery students in both maternity hospitals and to date would seem worthwhile and desirable. However, anecdotal evidence would suggest that the status of these midwifery students causes constraints to its full implementation and. The second factor that made it essential to support the direct entry midwifery students was the fact that maternity services in Ireland were, and are still, experiencing difficulty in recruiting and retaining midwives and midwifery students, especially within the Dublin area. This dearth of midwives, exacerbated by the national increase in the birth rate, led to a situation where midwives were fully engaged in giving clinical care with no time left to guide or supervise students closely.

7.2 A model of preceptorship

An innovative approach to supporting this group of midwifery students emerged. A preceptor, who was an experienced midwife and supernumerary to the rostered midwifery team, was responsible for
creating and facilitating a learning environment in practice for two direct entry midwifery students, for a period during the first year of the programme. Ten midwives acted as fulltime preceptors with three acting as relief for leave (sickness and annual). This period of preceptorship by supernumerary preceptors was for 18 weeks out of the total of 22 weeks allocated to midwifery practice in year one. It was envisaged that this would be spread across the year from week 11 to 42 with midwifery students in practice 3-5 days per week interspersed with 0-2 study days per week, three weeks theory block and four weeks annual leave. However, a number of difficulties were identified with the suggested organisation of this period. The midwifery managers pointed out that recruiting midwives to replace supernumerary preceptors would be difficult given the existing shortage of staff. In addition, given the spread of the preceptorship period i.e. over a 31 week period, replacements would be needed for the full period but funding was only available for eighteen weeks, and the role of supernumerary preceptors whilst the students were in theory block/study day or annual leave was unclear. The preceptorship period which was agreed at the Direct Entry to Midwifery Steering Group meeting on 27th January 2000 was for a continuous period of preceptorship for eighteen weeks from week 12 to 29 in the first year of the programme.

In view of the uniqueness of the programme, it was deemed appropriate to define the role and responsibilities of these midwives/preceptors for the preceptorship period (see Curricular Document), some of which are outlined here. Each preceptor midwife was supernumerary to the rostered midwifery team but was expected to respond appropriately and exercise professional judgment in the case of emergency situations when the midwifery team required help and support. During this eighteen week period of practice, preceptor midwives remained employees of their respective hospitals. They also remained responsible and accountable for their own practice and reported any midwifery care issues through the normal midwifery management systems.

A detailed evaluation of the preceptorship period – structures, processes and outcomes - was undertaken. Appendix ? details the timeframe of this evaluation.

7.3 The preceptorship period – structures
In both the linked maternity hospitals the position of supernumerary preceptor was advertised. Thirteen midwives volunteered and were selected, 9 in The Rotunda Hospital (7 fulltime and 2 relief) and 4 in Our Lady of Lourdes, Louth/Meath Hospital Group, NEHB, Drogheda (3 fulltime and 1 relief). All were registered general nurses and registered midwives. The majority of the midwives stated that they volunteered because of the desire to be involved in something new and challenging and the desire to be more involved in teaching midwifery students. Their midwifery practice experience ranged from 3 years to 14 years and 4 months.

A 40 hour programme of ‘Teaching, learning and assessing in midwifery practice’ was developed, implemented and evaluated (see Curricular Document). Funding had been provided for replacement of these midwives while they undertook the education programme. Midwives completed a detailed questionnaire on commencement and on completion of the education programme (see Appendix ? for the timescale of the evaluation process). The programme and its evaluation were completed before these midwives commenced the period of preceptorship with the Diploma in Midwifery (Direct Entry) students. The findings from this evaluation are detailed in a paper by Daly and Carroll (2001). The pertinent findings related to this evaluation are presented here.

### 7.3.1 Evaluation of the ‘Teaching, learning and assessing in midwifery practice’ programme

At the commencement of the programme, eleven (85%) of the midwives had previously felt adequately prepared to teach midwifery students. However, as a result of undertaking the programme, they indicated a greater level of preparedness. Statements from the midwives include: ‘I am now much more aware of the way to teach…also not to teach too much at one session…’; ‘the feedback from the teaching sessions has reinforced the fact that…I am well capable and have the knowledge’; ‘I’m more focused on the needs of the student’; ‘I am more aware of the importance of preparation’; ‘the programme opened my eyes to what’s involved and the enormity of the responsibility’; ‘highlighted student’s particular needs’; ‘the practice sessions reinforced the level of knowledge I have’; ‘the programme has changed the way I feel about teaching and has made me much more aware of needs’ and ‘I can concentrate more on the students’ needs rather than my own’ (Daly and Carroll 2001). Similarly, all midwives had indicated their confidence in teaching midwifery students but indicated an increased confidence in their ability following the programme. All midwives stated that the programme had met their expectations with two stating that it had exceeded them. In the final evaluation, there was
majority agreement amongst midwives, managers and teachers (n=85, 60%) that the preparation of supernumerary preceptors was adequate.

7.4 The preceptorship period – process

The preceptorship period began on 14th August 2000 and was completed on 17th December 2000. One supernumerary preceptor preceptored two midwifery students (forming a triad). The students and preceptors rotated into all areas of midwifery practice within the maternity hospital. An initial period of one to two weeks was spent in each area for the purpose of orientation. Midwifery students spent a half day each week in the classroom in their respective maternity unit in order to maintain the link between theory and practice. The theoretical input of these sessions was very much driven by the needs of the midwifery students during this time. When the students were in class, this provided the preceptors with time for reflection and preparation.

The allocation of preceptor and students to each triad was random and no attempt was made to ‘match’ people. The ensuing relationship within this triad was not without its difficulties and this forms part of the evaluation and is reported on in the next section. During this period one midwifery student withdrew from the programme. In one case where a preceptor/student dyad was encountering problems, one of the students was reallocated to the preceptor with one remaining student.

7.5 The preceptorship period - outcomes

Evaluation of the preceptorship period was carried out at two points (see Appendix ?). Both preceptors and midwifery students completed questionnaires at both these points and this was followed by group discussions involving all key stakeholders – midwifery students, preceptors, midwife teachers and managers and midwives. The aim of these evaluations was to gain insight into this period of preceptorship from the students and the preceptors, but also from the other key stakeholders. With regard to the midpoint evaluation, the aim was to consider and address issues that required immediate attention and to consider how best to proceed. In order to maintain anonymity, as there was only one male preceptor, the female gender ‘she/her’ or ‘my preceptor’ will be used throughout the quotes used to illustrate points. Data from the preceptors’ evaluations at the midpoint in the preceptorship period were presented by Deirdre Daly at the Triennial Conference of the International Confederation of Midwives in Vienna 2002 (Daly and Carroll 2002). Extracts from this paper are included in this chapter.
7.5.1 Experience of the preceptorship period – midwifery students

Nine weeks into this period, students described their enjoyment of learning and acquiring new skills and knowledge, and the sense of achievement this gave them. In achieving this, they identified supernumerary preceptorship as ‘invaluable’. A number of students stated that ‘without the preceptor we would be lost’. The value of being able to learn ‘through a hands on approach’ was appreciated. Receiving encouragement and support was also appreciated. By the endpoint the commonest strength described by students was the amount of experience gained and the learning achieved. Students were also likely to comment on the value of always having ‘somebody there to seek advice from’, ‘never felt alone’.

At the midpoint evaluation, the majority of students (n=11; 58%) stated that they felt well supported and valued in the practice environment with the remainder stating that they felt moderately supported and valued. The helpfulness and willingness of staff, as one student said, ‘to point you in the right direction’ was referred to by many students. Many students also qualified this statement by referring to the support received from the preceptor. One student said that she felt well supported ‘because I am sheltered by my preceptor at all times’. A number of students (n=6; 32%) commented that some staff made them feel an inconvenience, invisible, lacking nursing skills and were ‘a little hostile’. At the endpoint, the sense of being supported and valued in the practice area had increased with 14 (78%) students describing themselves as feeling well supported, 3 (17%) moderately and 1 (6%) poorly.

Students described the strategies used by their preceptors to ensure that they got the best educational experience in the practice environment. Several students referred to the preceptor seeking out/looking for opportunities to facilitate the student’s learning. A recurring theme was the ability of the preceptor to allow the student to set their own pace by recognising when they were ready ‘to move on’, ‘comfortable with it’. The students also appreciated the explanation and rationale for midwifery practice and commented on the preceptor providing the evidence for practice. Being allowed to ‘get on’ with giving care rather than observing was also valued. Eleven midwifery students (58%) stated that they were helped to identify learning needs at the beginning of each day/week/placement with 8 (42%) responding to that in the negative. At the endpoint evaluation, when asked if they were helped to
identify their individual learning needs, 9 (50%) students stated that they ‘always’ were, 5 (28%) ‘sometimes’, 2 (11%) ‘never’ and 1 (6%) student did not respond. Table 7.1 illustrates how their preceptor responded to their individual learning needs. One student did not respond to the question at the endpoint evaluation.

At the midpoint evaluation, the intensity of the triad relationship between two midwifery students and preceptor began to emerge as a weakness of the preceptorship period for both students and preceptors. Five students (26%) identified this issue describing it as creating feelings of ‘tension’, ‘stifling’, and a sense of ‘lack of space’. It is aptly illustrated by one student’s comment: ‘the intensity of the 3 is very hard. Spending every minute of every day together is very demanding, especially if there are personality clashes. This has been a down side for me’. By the endpoint evaluation, three students (17%) commented on the intensity of and difficulties in their relationship with the preceptor alone and/or with the other midwifery student in the triad. At this point, midwifery students were asked if they would have liked to change preceptor midway through the preceptorship period. Equal numbers said they would and would not. Two students added comments to their reply and based on their comments a small majority (n=11; 58%) would favour a change midway. In relation to a change of midwifery student partner midway, the majority (n=11; 58%) said ‘no’, 4 (22%) ‘yes’ and 3 (17%) were undecided.

The intensity of the period itself was also identified as a weakness by three students (17%) and is illustrated by this student’s comment: ‘I’ve struggled with the intensity of the 18 weeks, lack of space and time for learning and overload of information during the eight hours’. Two students (11%) were...
concerned about becoming dependent on the preceptor, as one stated ‘I don’t know what I am going to do when I am on my own without her in February’. Only practising with one midwife concerned two students as one student commented ‘We only get to see how one midwife handles a situation or practises in any given situation. I also feel this prevents us from being taught by the staff midwives in the practice areas who are used to this role and who have many valuable contributions to make’. Other comments included: lack of feedback; restrictions placed on preceptors by midwifery management; pressure resulting from comparing the practice experiences of one group with another resulting in them feeling pressurised; and inadequate theory prior to the preceptorship period.

As, by the endpoint of the preceptorship period the majority of students would have practised with another preceptor (relief for annual/sick leave), they were asked to comment on the strengths of practising with another preceptor. The majority commented on the value of seeing ‘a different way of doing things’ as illustrated by the following comment: ‘It was good to see and hear how another midwife approached midwifery practice and theory’ and ‘It was wonderful getting another’s viewpoint. Some preceptors had been trained here in Ireland and others in England and it was amazing to see the difference in practice’. When asked to comment on the weaknesses of practising with another preceptor the comments were almost a contradiction to those identified as a strength: seeing practice that contradicted/conflicted with that already experienced and receiving conflicting information. However, many students prefaced their comments by suggesting that this was ‘not necessarily a negative thing’ as illustrated by this comment: ‘….as midwives practice is full of adaptation and we must be adaptable, this is no bad thing’. Other comments included; unsettling, the need to develop the relationship, and need to establish the level the student is at.

7.5.2 Experience of the preceptorship period – preceptors

For preceptors, the supernumerary status of the student and the absence of responsibility were perceived as strengths of the preceptorship period both at the midpoint and endpoint evaluations. This was combined with having ongoing teaching from a skilled midwife who was present constantly. Students were described as being able to work independently in some areas after nine weeks of practice and by the endpoint were described as having learned ‘a huge amount’. The preceptorship period was described as giving students great support to develop their skills without undue stress. The lack of case load/ward management responsibilities meant that they did not have to undertake anything without
being confident. The main weakness of the preceptorship period identified at the midpoint was in relation to the supernumerary status of the preceptors and the ‘confusion/conflict’ this led to initially on busy wards (Daly and Carroll 2002). The twelve midwives (100%) made numerous references to staff shortages, the activity levels within the hospitals and how this led to their supernumerary status being overlooked. They stated that they had feelings of guilt at having to say ‘no’ to taking on a larger caseload and they referred to the ‘them and us’ situation that this created. Some midwives cited the lack of support from colleagues and management (see Table 7.2), coping with differing personalities and ‘envy’ portrayed by colleagues as weaknesses of the preceptorship period.

Table 7.2 Extent to which preceptors felt supported

<table>
<thead>
<tr>
<th></th>
<th>Midpoint (n = 12)</th>
<th>Endpoint (n = 7)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Well supported</td>
<td>Moderately well supported</td>
</tr>
<tr>
<td>By midwifery colleagues</td>
<td>5 (47%)</td>
<td>7 (58%)</td>
</tr>
<tr>
<td>By midwifery managers (practice)</td>
<td>6 (50%)</td>
<td>5 (47%)</td>
</tr>
<tr>
<td>By midwifery managers</td>
<td>4 (33%)</td>
<td>4 (33%)</td>
</tr>
<tr>
<td>By midwife teachers</td>
<td>11 (92%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>By course co-ordinator</td>
<td>11 (92%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>By others:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellow preceptors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>not included at midpoint</td>
<td></td>
</tr>
</tbody>
</table>

Some midwifery colleagues were described as making the preceptors feel as if they were ‘skiving’ or ‘taking a holiday’ and this left the preceptors feeling as if they constantly had to justify their actions. Some colleagues were described as ‘begrudging’ the preceptors their role (Daly and Carroll 2002). By the end of the preceptorship period this issue may have resolved itself to a great extent with three (43%) of the seven respondents referring to this again as a weakness but prefacing their responses with ‘initially’, ‘occasionally’.
Preceptors also viewed having two students together constantly as a possible weakness of the preceptorship period. The midwives stated that in order to avoid conflict, the students had to ‘gel’ and the preceptor had to ‘gel’ with them. One midwife said that students may have nothing in common apart from the course and may not even like each other and described this as creating a feeling of ‘schizophrenia’ for the preceptor. Three midwives (43%) suggested that a change of preceptor and of the student pair should be considered at a half-way point in future programmes. At the endpoint evaluation, one midwife said that two students ‘stuck’ together and not getting on may have interfered with their learning until they sorted out their differences. Others suggested that future programmes include workshops on how to deal with personality difficulties and to consider reducing the contact time per week between preceptor and student. In this aspect of the evaluation, several references were made to the ‘big shock’ these students would experience at the end of the preceptorship period when they would be ‘alone in practice’ i.e. without the preceptor. Reference was also made to the fact that they were not part of the team and the students feeling that they were different from the other midwifery students.

7.5.3 Preceptors’ experience of teaching and assessing in midwifery practice

During the preceptorship period, the midwife’s role was to facilitate the learning needs of the midwifery students. Nine weeks into this period all the midwives indicated that their approach to teaching had altered (Daly and Carroll 2002). Several referred to the value of feedback, repetition and recapping in practice and to the fact that a student saying ‘yes’ or nodding their head did not mean that they knew or understood what was being taught. The midwives referred to the importance of providing students with explanations and feedback; developing a clear understanding; consolidating information and ultimately ensuring that students understood the information. A recurring theme in this area was the ability to participate in care giving and having time to reflect on the care given. Learning according to what was seen and experienced rather than covering irrelevant theory was seen as aiding learning (Daly and Carroll 2002). By the endpoint evaluation, five (71%) of the midwives agreed that their approach to teaching had ‘greatly altered’, with one (14%) agreeing that it had ‘altered’ and one (14%) that it ‘has not altered’. They stated that they would approach a teaching session by first assessing prior knowledge and the level the student ‘is at’. Reference was also made to the importance of involving the students, using questioning and self assessment, and allowing time for reflection.
At the midpoint evaluation preceptors made several references to the fact that the preceptorship programme gave a real opportunity to teach without the strain of a workload (Daly and Carroll 2002). The absence of ‘strain’ was described as providing the midwives with greater ‘patience’ to teach midwifery students. The opportunity to share knowledge without having the responsibility of routine ward work was seen as a major strength for these midwives. Several references were made to the absence of shift work and night duty meaning that they were not as stressed or exhausted and ultimately more ‘enthusiastic’ about teaching. By the endpoint evaluation, supernumerary preceptorship was referred to by one midwife as being essential for the ‘confident knowledgeable member of the midwifery team’ the students had become while one midwife referred to having the actual time to teach students.

References were made to focusing on the students’ needs and learning requirements and the students being able to cope with ‘only so much’. Whilst the preceptorship period to date was described as hard work and tiring, a recurring theme in this section was the use of the term ‘enjoyment’. Implicit in this was an increased confidence in teaching and student focused teaching. The midwives referred to gaining satisfaction and enjoyment from seeing the student learn. All of the midwives referred to seeing the Diploma in Midwifery (Direct Entry) students learn and develop and appeared to gain satisfaction and enjoyment from observing their growth in knowledge (Daly and Carroll 2002).

7.5.4 Preceptors’ ability to teach and assess in midwifery practice

Nine weeks into the preceptorship programme, eleven (92%) of the midwives indicated that their confidence in their ability to teach had increased (Daly and Carroll 2002). Some of the midwives indicated that having a close relationship with two students meant that the information they were imparting was ‘questioned’. Whilst this was viewed as somewhat disconcerting, it was also seen as a ‘good thing’. Some of the midwives had a degree of worry regarding the ‘amount’ they were teaching, but indicated that seeing students learn and progress provided them with both enjoyment and encouragement. The midwives described their ability to convey knowledge as ‘developing’ (Daly and Carroll 2002). By the endpoint evaluation three (43%) of the midwives described gaining confidence in their ability to teach over the eighteen weeks. Midwives stated that their teaching was now in response to the student’s identified needs and also encouraged student involvement instead of ‘spoon feeding’. At
the midpoint one midwife indicated that a degree of doubt persisted in relation to the assessment of practice. This statement was linked to giving ‘negative’ feedback and the conflict this created. Coping with conflict and giving ‘constructive feedback’ were topics addressed in the ‘Teaching, Learning and Assessing in Midwifery Practice’ programme but perhaps, as with other issues, it is only when they are real and experienced that they become truly meaningful. By the endpoint, the majority described their ability to assess and give feedback as improved and that their confidence in their ability to give constructive feedback, both positive and negative, had grown. It was, however, an area that many midwives would like further input on.

Issues that would enhance/facilitate further confidence were identified (Daly and Carroll 2002). At the midpoint evaluation, these related to the availability of textbooks and teaching aids at ward level as well as contemporaneous policies, protocols and procedure manuals. These midwives were unique in that they rotated through all areas of the hospitals in the eighteen week period and they indicated that being ‘new’ to an area sometimes led to difficulty in ‘finding ones’ feet’ in the absence of the aforementioned protocols. Several midwives referred to needing more time to continue developing their teaching and assessing skills. Some midwives elaborated on this statement by saying that additional lectures on teaching strategies would be beneficial. One midwife would have welcomed additional input on giving constructive feedback. By the endpoint evaluation, midwives referred to the need to continue to ‘avail of every opportunity’ to teach midwifery students so that these skills would be enhanced and ‘not lay dormant’. Now that they would no longer be supernumerary, they suggested the need for time, and to make time, to teach students and the benefits of students being allocated a named preceptor.

At the time of the ‘Teaching, Learning and Assessing in Midwifery Practice’ programme evaluation, all of the midwives stated that the programme had prepared them to teach and that their confidence in their ability to teach had increased (Daly and Carroll 2001). At nine weeks into the preceptorship period, the comments were less positive and the majority of the midwives now stated that whilst the programme did help, it was only when they started working as a preceptor that it all came together (Daly and Carroll 2002). Several references were made to the fact that the programme did make a difference but that there were some aspects which can only be learnt through actual experience. These comments are interesting when one considers that these midwives were previously expected to be engaged in teaching Postgraduate Diploma in Midwifery students on an ongoing basis (Daly and Carroll
At the endpoint evaluation, midwives identified the practice teaching sessions as a strength within the programme as it gave them confidence and made them focus the content to student needs. Midwives also identified that learning from each other was helpful. They suggested that greater emphasis needed to be given to developing the skills of giving constructive feedback to students and dealing with conflict.

7.5.5 Midwifery students’ views of their preceptor(s)

Students were asked about the qualities that they found helpful in their preceptor. They were also asked to ascribe the ‘word’ which best described the relationship with their preceptor (see Table 7.3).

Table 7.3 ‘The word that best describes the relationship you have had with your preceptor’

<table>
<thead>
<tr>
<th></th>
<th>Midpoint n = 19</th>
<th>Endpoint n = 18</th>
<th></th>
<th>Midpoint n = 19</th>
<th>Endpoint n = 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>10 (53%)</td>
<td>13 (72%)</td>
<td>Facilitative</td>
<td>11 (58%)</td>
<td>14 (78%)</td>
</tr>
<tr>
<td>Domineering</td>
<td>3 (16%)</td>
<td>3 (17%)</td>
<td>Controlling</td>
<td>5 (26%)</td>
<td>4 (22%)</td>
</tr>
<tr>
<td>Rewarding</td>
<td>9 (47%)</td>
<td>11 (61%)</td>
<td>Open</td>
<td>13 (68%)</td>
<td>13 (72%)</td>
</tr>
<tr>
<td>Overprotective</td>
<td>3 (16%)</td>
<td>2 (11%)</td>
<td>Respectful</td>
<td>14 (78%)</td>
<td>14 (78%)</td>
</tr>
<tr>
<td>Supportive</td>
<td>15 (79%)</td>
<td>14 (78%)</td>
<td>Encouraging</td>
<td>Endpoint only</td>
<td>12 (67%)</td>
</tr>
<tr>
<td>Unhelpful</td>
<td>-</td>
<td>-</td>
<td>Restricting</td>
<td></td>
<td>4 (22%)</td>
</tr>
</tbody>
</table>

At the midpoint students identified qualities such as being knowledgeable, experienced and having the ability to teach; as one student stated ‘She’s a natural teacher, competent and confident ……… and if I can keep her teachings in mind I don’t think I’ll go far wrong’. The majority of students also identified affective qualities that focused on creating an environment that enabled them to learn. Illustrative comments include: ‘She is an excellent listener; patient; flexibility; empowering; responsive to my needs; focused on my learning’, ‘She is open, non threatening …… humorous, singularly lacking in egotism, happy to facilitate her students learning in a relaxed manner’, ‘She does not undermine and gives positive encouragement’. A further quality identified by five students was the preceptor’s interaction.
with women as illustrated by the following comment ‘Her attitude to women is so sincere and genuine’. By the endpoint evaluation, students began to identify the ability of the preceptor to allow them to practice independently as helpful as illustrated by this comment “I felt she enabled us to work independently when possible, which gives us confidence”. These comments on the helpful qualities their preceptor possessed are mirrored in some of the words selected by the majority to describe their relationship: positive, supportive, facilitative, open, respectful (see Table 7.3).

When asked about qualities that they found unhelpful, 8 students (42%) at the midpoint and 5 (28%) at the endpoint indicated that their preceptor did not possess unhelpful qualities. Unhelpful qualities identified are the opposite of those identified as helpful were lacked confidence/skills in certain areas of practice, lack of feedback on performance, adherence to policy at the woman’s expense and in fear of litigation, lack of structure and time management, attitude to both woman and student (aggressive, overbearing, mocking, undermining, defensive), overloading with theory. Again, these unhelpful qualities mirror the words selected by a minority of students to describe the relationship with their preceptor (see Table 7.3).

Students were asked to indicate their level of agreement/disagreement with a number of statements regarding their preceptor (see Table 7.4). The majority of students agreed /strongly agreed that their preceptor wanted the best out of this period for them and possessed the characteristics identified with successful acquisition of knowledge and practice. It would appear for 3 – 4 midwifery students they were either undecided or disagreed with this and in the analysis it was identified that these were the same students. With regard to statements 4 and 8, by the endpoint, students were more likely to agree/strongly agree that they were allowed to provide care independently and were less likely to feel that they were ready to undertake more than they were allowed to. This could be due to two factors: either the preceptor was more confident in the student’s ability to practice independently or students had achieved this level of independence and there was greater congruency between their assessment of their own capabilities and that of their preceptors. During the second half of this period preceptors were encouraged to facilitate students to practice with reducing levels of direct supervision.
Table 7.4 Students agreement/disagreement with statements regarding their preceptor

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My preceptor wants the best out of this period of midwifery</td>
<td>Mid N = 19</td>
<td>-</td>
<td>-</td>
<td>3 (16%)</td>
<td>5 (26%)</td>
</tr>
<tr>
<td>practice for me</td>
<td>End N = 18</td>
<td>-</td>
<td>-</td>
<td>4 (22%)</td>
<td>5 (28%)</td>
</tr>
<tr>
<td>The preceptor explains everything as we go along</td>
<td>Mid N = 19</td>
<td>-</td>
<td>1 (5%)</td>
<td>3 (16%)</td>
<td>4 (21%)</td>
</tr>
<tr>
<td></td>
<td>End N = 18</td>
<td>-</td>
<td>-</td>
<td>4 (22%)</td>
<td>5 (28%)</td>
</tr>
<tr>
<td>My preceptor does not help me to apply theory to midwifery</td>
<td>Mid N = 19</td>
<td>8 (42%)</td>
<td>7 (37%)</td>
<td>-</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>practice</td>
<td>End N = 18</td>
<td>7 (39%)</td>
<td>8 (44%)</td>
<td>-</td>
<td>3 (17%)</td>
</tr>
<tr>
<td>My preceptor allows me to care for women independently</td>
<td>Mid N = 19</td>
<td>1 (5%)</td>
<td>5 (26%)</td>
<td>-</td>
<td>6 (32%)</td>
</tr>
<tr>
<td></td>
<td>End N = 18</td>
<td>-</td>
<td>3 (17%)</td>
<td>-</td>
<td>5 (28%)</td>
</tr>
<tr>
<td>Feedback from my preceptor is helpful and supportive</td>
<td>Mid N = 19</td>
<td>3 (16%)</td>
<td>-</td>
<td>-</td>
<td>6 (32%)</td>
</tr>
<tr>
<td></td>
<td>End N = 18</td>
<td>1 (6%)</td>
<td>4 (22%)</td>
<td>-</td>
<td>4 (22%)</td>
</tr>
<tr>
<td>My preceptor encourages me to do things when I am reluctant to</td>
<td>Mid N = 19</td>
<td>1 (5%)</td>
<td>1 (5%)</td>
<td>4 (21%)</td>
<td>7 (37%)</td>
</tr>
<tr>
<td>because I lack confidence</td>
<td>End N = 18</td>
<td>-</td>
<td>1 (6%)</td>
<td>3 (17%)</td>
<td>6 (33%)</td>
</tr>
<tr>
<td>My preceptor is afraid to let me practice core midwifery skills</td>
<td>Mid N = 19</td>
<td>9 (47%)</td>
<td>7 (37%)</td>
<td>-</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td>End N = 18</td>
<td>10 (56%)</td>
<td>7 (39%)</td>
<td>-</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>I feel I am ready to do more than my preceptor lets me</td>
<td>Mid N = 19</td>
<td>3 (16%)</td>
<td>5 (26%)</td>
<td>6 (32%)</td>
<td>3 (16%)</td>
</tr>
<tr>
<td></td>
<td>End N = 18</td>
<td>5 (28%)</td>
<td>8 (44%)</td>
<td>2 (11%)</td>
<td>3 (17%)</td>
</tr>
</tbody>
</table>

7.6 Final evaluation – supernumerary preceptorship

In the final evaluation key stakeholders were asked their level of agreement/disagreement with a number of statements regarding supernumerary preceptorship period in year one (see Table 7.5). There was majority agreement that this model of preceptorship was an indispensable part of the programme and that without it midwifery students would have been ‘lost’ in practice placements. In the focus group interviews, midwifery students were absolutely adamant that they could not have done without
supernumerary preceptors in year one. One commented: ‘It's got so busy in both hospitals that that 18 week preceptorship course in invaluable and I don't think anything can replace that for a direct entry student going out onto the wards’.

Table 7.5 Views of supernumerary preceptorship at the final evaluation

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
<th>Missing value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 18 week preceptorship period in year one was invaluable</td>
<td>N 4</td>
<td>7</td>
<td>48</td>
<td>81</td>
<td>13</td>
<td>3</td>
<td>156</td>
</tr>
<tr>
<td>%</td>
<td>3%</td>
<td>5%</td>
<td>31%</td>
<td>52%</td>
<td>8%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>Without the guidance of ‘supernumerary’ preceptor(s) in year one, ‘direct entry’ midwifery students would have been ‘lost’ in practice placements</td>
<td>N 3</td>
<td>9</td>
<td>58</td>
<td>70</td>
<td>13</td>
<td>3</td>
<td>156</td>
</tr>
<tr>
<td>%</td>
<td>2%</td>
<td>6%</td>
<td>37%</td>
<td>45%</td>
<td>8%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>Fundamental midwifery skills of ‘direct entry’ midwifery students were learned during the 18 week preceptorship period in year one</td>
<td>N 8</td>
<td>37</td>
<td>60</td>
<td>16</td>
<td>23</td>
<td>12</td>
<td>156</td>
</tr>
<tr>
<td>%</td>
<td>5%</td>
<td>24%</td>
<td>39%</td>
<td>10%</td>
<td>15%</td>
<td>8%</td>
<td>100%</td>
</tr>
<tr>
<td>A different form of preceptorship in year one would have been equally as good</td>
<td>N 22</td>
<td>54</td>
<td>30</td>
<td>3</td>
<td>31</td>
<td>16</td>
<td>156</td>
</tr>
<tr>
<td>%</td>
<td>14%</td>
<td>35%</td>
<td>19%</td>
<td>2%</td>
<td>20%</td>
<td>10%</td>
<td>100%</td>
</tr>
</tbody>
</table>

In the focus group interviews, one manager also identified how busy the practice environment was and that she was not sure that the midwives would have had the same amount of time that the preceptors did to teach especially core skills e.g. measuring blood pressure, a skill they may never have taught midwifery students. Midwife teachers expressed the views that it nurtured the culture/ethos of the direct entry to midwifery programme and was perceived as the bedrock of the programme. This group as a whole believe that the period should be longer, a view that was further supported in the responses from midwives about what they would like to see changed in the programme. During the focus group interviews with midwives, they constantly referred to how indispensable supernumerary preceptorship was. One said ‘I don’t think it could be done without it. I don’t think they would have done quite so
well. And I think the staff would have turned against the programme a bit, if they were left to it.

Midwife managers agreed that the relationship that developed between the student and preceptor was important in relation to knowing the level of skills and knowledge the students were developing. As one said ‘It would be very easy for the students to not take the initiative to do something and to hold back, whereas when the preceptor is there, you’re encouraged to go ahead and do it’. Midwifery students’ comments also illustrate the value that they placed on the relationship that develops between preceptor and student. One student said ‘People who don’t have that intimate experience of working with you, don’t know what you’re capable of. It would be highly dangerous, I think, to have people supervising us who didn’t really know us.’ Another said: ‘We would have been so dangerous, you know, we really would, because we thought we knew loads at the time. We knew absolutely nothing, in hindsight.’

Fewer people agreed that ‘direct entry’ midwifery students had learned fundamental midwifery skills during this period (see Table 7.5). However, almost all midwifery students agreed with this statement and the members of the students’ focus group whole-heartedly agreed that they learnt their skills out in the practice area in that first 18-week period, and then could add in the theoretical knowledge afterwards, when it made much more sense. One said: ‘That was fantastic because then you came back into the classroom, like, it was like all the pieces of a jigsaw fitting together…’Oh, yeah, that’s why she did it that way!’.

Approximately 20% agreed that a different form of preceptorship would have been equally as good. When this was explored with each group in the focus group interviews, not only did each group disagree but all were unable to suggest an alternative. One midwife wondered if preceptorship (mentorship) as implemented in the UK was being suggested.

### 7.7 Discussion and conclusion

The degree to which students learned, gaining knowledge, skills and attitudes, was identified by both students and preceptors. Students learned effectively by being present in practice and coached through experiences by experienced practitioners. This is often stated as missing in university based programmes ([Refs??]). Other studies have described students as learning by ‘trial and error’ and ‘on women’ and that
learning in practice has been found to be focused on getting the ‘work done’ (Begley 1997). This is in contrast to how this group of students described how they learned. For most students, learning was enjoyable. They were able to question practices in contrast to feeling the need to ‘fit in’ and conform to the norm (Begley 1997). This preceptorship period of practice provided a safe environment, conducive to learning. Preceptors acted as a buffer for the students to an extent. This was a new programme, not without its advocates and detractors. Needing ‘to be a nurse first’ is a long held belief and has led to the demise of direct entry midwifery in many countries during the 20th century. Introducing a method of education and training different to that which the majority have experienced can be seen as threatening (this issue needs to be explored further). The preceptors, however, protected the students from this to an extent, and over the period of the preceptorship enabled the acceptance of the ‘direct entry’ midwifery student as legitimate, or at least as a legitimate alternative to the Postgraduate Diploma students.

There was a considerable, and welcome, increase in the confidence and ability of the preceptors to teach and assess students in practice, which should have beneficial effects on the education of all students in the clinical area. Midwives also described themselves as personally and professionally benefiting from the period. It gave them time to teach and think and may have a positive influence on their practice into the future. They were afforded the opportunity to renew their skill and knowledge of all aspects of midwifery practice. Granted it does not require a programme such as this to facilitate such development; however, it was seen by midwives as beneficial. Responding to students’ knowledge and skill needs also provided them with the opportunity, and perhaps more importantly, the motivation to engage in updating their own knowledge and skills. Giving and receiving constructive feedback has emerged as an area to be developed with preceptor and with students. Preceptors need the skills and practice to be able to give constructive feedback. Students need to develop the skills of seeking and receiving feedback as an important component of learning.

Weaknesses related to the structure and process rather than to this model of preceptorship. There was total agreement with the necessity for preceptorship for this group of midwifery students (and anecdotally for all midwifery students). The intensity of the 18 week period without a period of annual leave was an issue for many students (Preceptors had two weeks annual leave during this period). As already discussed, this was unavoidable within the pilot programme in view of the funding allocated for
the replacement of the preceptors. Some personality difficulties within the triad contributed to weakening this valuable learning experience. As suggested by students and preceptors, consideration needs to be given to a change of preceptor and student partners at the midpoint. However, this will not overcome the possibility of personality difficulties. Possibly placing a greater emphasis within the programme for midwifery students and preceptors on managing difficult relationships, assertiveness skills and working in a team may help to address this difficulty.

As already discussed in chapter six, the 18-week preceptorship period in year one of the programme had facilitated the development of a culture where supervision and feedback to students became the norm. It became part of daily practice. They further stated that even now when the practice site is busy, time is set aside by preceptors to work with their allocated students and ensure that they are doing the right activities to meet the competencies that are been worked at. The actual nature of assessments and the evidence that has to be provided by the students to their preceptors requires at least an hour of time and this is made available. There is a complete shift where for the first time the midwifery student has become the centre of attention. The supernumerary status given to the preceptors in the initial 18-week period underscored the importance that was been attached to supervision and feedback and this permeated down to all midwifery staff.

7.7.1 Recommendations

- Maintain supernumerary preceptorship as an integral part of the programme;
- Review the structure of the 18 week period to reduce the intensity for the midwifery students, include an annual leave allocation, alternative/varied allocation of students and preceptors;
- Review the content of the ‘Teaching, learning and assessing in midwifery practice’ programme putting greater emphasis on giving and receiving constructive feedback, managing difficult relationships, assertiveness skills, working in a team;
- Review the incremental nature/needs of the preceptor in practice during the preceptorship period and provide support to meet those developmental needs regarding teaching, learning and assessing in practice.
Chapter Eight

Practice placements – sourcing, auditing and evaluating

8.1 Introduction

This chapter mainly focuses on the evaluation of external placements (that is external to the two linked maternity hospitals – Our Lady of Lourdes, Drogheda and The Rotunda Hospital) undertaken by the students in year two of the programme. An overview of the placements within the two linked maternity hospitals will first be provided and the amount of time students practise in each site. In the 1st half of year two students undertook a four week medical/surgical placement in St. James’s Hospital, Dublin. The appointed facilitator of that placement carried out an evaluation with the students and the practice areas. At this point it has not been possible to obtain a copy of this evaluation but it is hoped that it will be included in the final evaluation.

8.2 Placements in the two linked maternity hospitals

At the first meeting of the Direct Entry to Midwifery Steering Committee it was decided that students should undertake placements in both linked maternity hospitals, 70% in The Rotunda Hospital and 30% in Our Lady of Lourdes, Drogheda. The reasons for this decision is not recorded in the minutes but the general view held is that experiencing practice in both sites would expose the students to possibly different approaches to delivering maternity services. It was planned that the 70%/30% split would be achieved over the three years of the programme rather than in each year. In the first year, students would experience the majority of practice, 18 week out of a total of 22 weeks, with their supernumerary preceptor. In planning the preceptorship period students were allocated to a preceptor for the total period. Consequently students would either practice in The Rotunda (14 students) or Our Lady of Lourdes, Drogheda (6 students) for that period. The allocation of students to Drogheda for the preceptorship period was done solely on who appeared to live nearest the site. The difficulty of travelling to Drogheda began to emerge and at the Direct Entry to Midwifery meeting on 6th December 2001 the student representative asked for a degree of flexibility with the allocation of students to Drogheda. It was agreed that some flexibility be allowed and students’ views were sought before the
allocation for year three was completed. It was also agreed that all students have at least one placement in each hospital during year three and that they have a labour ward placement in each during the programme. As already discussed in Chapter Six, the majority of students agreed that there were benefits to practising in both hospitals.

8.3 Overall evaluation of external placements undertaken from February to May 2002

Placements external to the two linked maternity hospitals took place between February and May 2002 (except for the medical/surgical placement which occurred from October to November 2001). These placements were: community midwifery – 3 weeks; paediatrics – 2 weeks; community (including community psychiatry, women’s refuge, Drug Liaison Midwife) – 3 weeks; and elective – 2 weeks. Twelve midwifery students completed the evaluation of these placements. Nine students agreed that the arrangements made regarding the placements suited them while 3 disagreed. All but one student stated that they were able to attend all the placements; this student was ill during a community psychiatric placement and it was not possible for her to undertake that placement again. The majority (8) of students disagreed that they were able to arrange their elective placement without difficulties. When asked if the placements should be spread over year two as a whole, 5 agreed with 7 disagreeing. All students agreed that the external placements were valuable for gaining an understanding of the Health Services in Ireland and that the placements broadened their knowledge of women’s health and social issues in Ireland. The financial impact of undertaking placements away from The Rotunda/Drogheda impacted on most students, ranging from €16 – 1,100. It is somewhat difficult to interpret some of the information provided. The placement in Crumlin apparently cost one student €150; however parking is available for less than €2 a day and food is available within the hospital. For a number of students the additional cost of external placements put a strain on already difficult financial situations. Six students commented that it did not impact on them to any great extent with some commenting that family supported them.

Students were asked to suggest other placements that they view as being potentially beneficial to midwifery students. The following is a list of those suggested:
Finally the majority of students commented on how much they had enjoyed the placements and the benefit it was to them: ‘I really enjoyed my time in placements and feel that it developed me personally and professionally’.

### 8.4 Paediatric placement

A two week paediatric placement was undertaken in either Our Lady’s Sick Children’s Hospital in Crumlin or in the National Children’s Hospital in Tallaght. The achievement of placements in Crumlin was limited to a six week period from April 1st to May 12th. Again this was due to competition of other students in the placement during the period available i.e. Feb 18th to May 19th. Placements had also been sought in The Children’s Hospital, Temple Street and the Paediatric Unit in Our Lady of Lourdes, Drogheda. Again this was not possible due to the number of students in the placements at that time.

Overall, the three midwifery students who undertook the placement in Tallaght did not feel that the placement was relevant to them as midwifery students hence their disagreement with the statements regarding appropriateness, gaining knowledge and skills, informing midwifery practice. Four evaluations were received from the placement. In contrast, they unanimously agreed with all but two statements in the evaluation and emphasised the placement’s relevance to midwifery practice ‘This is a valuable placement as it allows students to see the aftercare of families after discharge from hospital’. One evaluation contained only one statement (from nursing administration) regarding the enthusiasm, motivation and energy of the students and that they ‘were a pleasure to have on our wards’.

<table>
<thead>
<tr>
<th>• Breast cancer, Cervical cancer,</th>
<th>• Refugee &amp; immigrant dept</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Social Worker /Social Work Dept x 4</td>
<td>• Midwifery led units x 3</td>
</tr>
<tr>
<td>• Travellers Health</td>
<td>• Public Health Nurses x 2</td>
</tr>
<tr>
<td>• Community work with Midwives</td>
<td>• Placements in the U.K.</td>
</tr>
<tr>
<td>• Longer time with drug liaison midwives and elective</td>
<td>• HARI unit</td>
</tr>
<tr>
<td></td>
<td>• Infertility clinics</td>
</tr>
</tbody>
</table>
Nine students completed evaluations for the placement in Crumlin. There was unanimous agreement with all the statements in the evaluation with one student disagreeing that: 1. the aims and learning outcomes for the placement were understandable; 2. it challenged her to learn new things; and 3. she had achieved the aims and learning outcomes. All students agreed that the placement benefited them personally with comments referring to learning about parent-child relationship, the effects of hospitalisation on a child etc. Three students commented on the time and expense of travelling to the other side of the city from The Rotunda. All agreed that it should be a placement undertaken by all students. The overall comments from the students were in relation to the supportive and welcoming staff as the following comment illustrates: ‘This was a very student friendly placement and the staff were most impressive – a very different model to the hierarchical systems we are used to’. Three evaluations were received from the placement. Staff in Crumlin were very positive about all aspects of the placement and commented that the students were ‘of a very high standard’ and ‘very interested in all aspects of ward work’. One person asked that there be more communication between course coordinator and staff on the wards.

It was also hoped that midwifery students would spend one week in both the Paediatric Outpatients Department (POPD) and Paediatric Unit (PU) of the Rotunda Hospital. Eight midwifery students achieved a placement, three in PU and 5 in POPD. All but one of these 8 students also achieved a two week placement in a children’s hospital, Crumlin or Tallaght. One student was allocated to POPD instead of a second week in the Women’s Refuge due to the nature of that placement. Three students completed an evaluation of the placement in POPD with unanimous agreement with all the statement. Students commented that this was a good learning experience especially in relation to babies over three days old. The evaluation completed from the placement commented on the positive learning experience the placement provided. The students were found to be capable and willing to participate. Two students completed the evaluation on the placement in PU. One student was positive about the placement with the other student disagreeing that it was a positive learning environment. There was no evaluation from the placement.

### 8.5 Community placement

A placement with the Public Health Nursing Service is regarded as an essential placement within this programme. Much time was spent trying to achieve such a placement but without success. Some of the
midwifery students individually were more successful in achieving this placement as part of their elective. One student did arrange two weeks with her local Public Health Nurse as part of the community placement. In her evaluation she said that one week would have been enough.

A one week placement was spent with one of three Drug Liaison Midwives attached to each of the three Dublin Maternity Hospitals. The majority of students evaluated this placement positively with all agreeing with statement 1-4, 7, 8, 11, 12. Four students indicated that they did not feel able to participate in practice on the placement, two that they did not feel part of the team, one that staff were not aware of their learning needs, one that the placement did not challenge her to learn new skills, and two that the placement did not meet their expectations. All but two students indicated that the placement benefited them personally as the following comment illustrates: ‘this placement opened my eyes and made me explore my views and feelings regarding women that use drugs while they are pregnant. I have a much better understanding of their reasons why and why giving up is such a problem for them’. Six students found the travelling difficult – needed a car to get to the different venues, parking was difficult to find and expensive. This difficulty arises due to the issue of the midwives being unable to carry students as passengers. All students would recommend the placement for other midwifery students some stating that it should be ‘obligatory’. One of the three midwives returned the evaluation form. She agreed with all statements in the evaluation stating that the students related well to the women, were enthusiastic and willing to learn. She recommended that the placement should be longer with more theoretical input prior to it, available to all midwifery students, and transport issues addressed.

Ten midwifery students were allocated to the Women’s Refuge in Rathmines for a two week placement. This proved to be a difficult placement for the midwifery students. Students discussed this with the course co-ordinators and raised it at the Curriculum Development Committee meeting on the 21st March 2001. Following discussion it was decided to continue with the placement but to contact the placement to discuss the level of supervision and support provided. A shortage of staff and new staff were posing difficulties but it was agreed that a staff member would mentor the students. From the responses in Table 9 it appears the students did not feel supported and part of the team whilst on the placement given that they spent most of their time in the company of the women and children in the refuge.
Table 9  Midwifery students’ evaluation of placement in Women’s Refuge

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  The aims and objective of the placement were understandable</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2  The placement was appropriate for midwifery students</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3  The knowledge and skills I gained is relevant to midwifery</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4  What I learnt on placement will inform my midwifery practice</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5  I felt able to participate in practice on the placement</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6  I felt part of the team whilst on placement</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>7  The learning environment was supportive</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>8  Staff in the placement were aware of my learning needs</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>9  The placement challenged me to learn new skills</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>10 The aims and objectives of the placement were achieved</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>11 Independent learning time (1 theory day per week) gave me time to learn/study/explore placement related issues</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>12 The placement met my expectations</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>13 I feel the placement benefited me personally</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>14 Travelling to/from the placement was easily achieved</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15 I would recommend this placement for other midwifery students</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

Students would not recommend this placement. One student’s comment aptly illustrate the comments from the other students: ‘I feel that this placement affected me the most and taught me to appreciate the things I have and how other people have such a hard life. ……. While I felt I personally as an individual grew from this experience I don’t feel it was any benefit to my midwifery knowledge or to my skills. Maybe to communication skills it may have improved them. Even though I did enjoy the placement and grew very fond of the women but found it very stressful’.

Seven midwifery students were allocated to spend one week in a community psychiatric placement. Although it was hoped to provide all students with this placement this was not possible for two reasons: 1. students from other programme were also on placements and 2. the inflexible timeframe of 18th Feb – 19th May. Placements were sourced in three different areas: Clondalkin Mental Health Services (3 placements), Gallen House, Howth (3 placements), and Newbridge (1). Two students completed the
placement in Clondalkin as one student was sick. Both students evaluated the placement very positively stating it was ‘very appropriate to my learning needs’, as they were involved with women experiencing psychiatric problems before and after childbirth. The placement also enjoyed having the students. They commented that one week was short in which to gain a true understanding of mental health issues and that there may not be women with mental health issues around the time of birth attending at all times. One student attended the placement in Newbridge for 2 days only due to illness. The student did not evaluate this placement positively but the length of time she spent there must be taken into consideration. Three students attended placements in Gallen House but did not complete evaluations. The placement evaluation was very positive stating that the students contributed positively and actively, they enjoyed having them and gained useful insights into midwifery. They did however expressed concern regarding the male:female balance in the placement.

8.6 Community Midwifery placement

Gaining and achieving community midwifery placements from the recently established community midwifery pilot programmes and self-employed midwives was a genuine aspiration of the programme and was achieved to a great extent. The Direct Entry to Midwifery Committee discussed this issue extensively and were agreed that if this programme is to achieve its aim of educating midwives to deliver midwifery-led services in the future, then this placement must be facilitated. It was agreed that a four week placement was both desirable and achievable within and without maternity services in Ireland. All providers of community midwifery services both within and without the health services were invited to provide placements. Those placement areas not currently approved for the education of midwifery students were invited to undertake an audit of their area of practice in order to gain approval for the purposes of providing midwifery educational experience. An audit tool based on The Requirements and Standards for the Midwife Registration Education (An Bord Altranais 2000) was devised for this purpose. Integrated Community and Hospital Midwifery Service, Waterford Regional Hospital and a number of self-employed midwives completed a self-audit of their area of practice and were approved.

The Direct Entry to Midwifery Committee discussed and agreed that the achievement of community midwifery placements also entailed the provision of the necessary funding to assist the midwifery students fulfil this essential requirement. Community midwifery placements were available for a
maximum of three midwifery students with the pilot programme in the National Maternity Hospital Dublin. There were however, twelve additional placements required for a period of four weeks, in four other centres. These include the projects at Galway, Waterford, Cork and Sligo.

No hospital accommodation was available in any of these sites. It was estimated that the cost of accommodation and subsistence away from the programme site would cost approximately £170 per week per student. Available was an external placement grant of £40 per week plus return travel allowance on public transport. A proposal for additional funding to facilitate this placement was submitted to the DOH&C.

Funding was also sought to facilitate a placement with self-employed midwives. Those self-employed domiciliary midwives who had indicated interest in facilitating such a placement and who had engaged in the approval process of their practice area, had requested the payment of a fee for facilitating such a placement. The fee requested is £190 (€241.25) per week. This had particular relevance to the pilot project of domiciliary midwifery in the Southern Heath Board in association with the Community Midwives Cork as the midwives were self-employed. This placement was especially of interest as it offered real opportunity for midwifery students to experience the delivery of care in a woman’s own home as well as possibly the opportunity to be present at a birth in the home. Without the possibility of accessing this scheme, the desired length of the placement was in jeopardy within the time constraints of the programme. The Direct Entry to Midwifery Committee agreed that funding should be requested for this placement.

Following discussions with the DOH&C additional funding was made available to facilitate the placement. However, funding was only made available for placements within the public health service. All midwifery students were afforded a three week placement with one of the recent pilot programmes: Community Midwives, National Maternity Hospital (4 midwifery students); Integrated Community and Hospital Midwifery Service, Waterford Regional Hospital (9 midwifery students); and Home Birth and DOMINO Scheme, University College Hospital, Galway (2 midwifery students).

Twelve students completed evaluations of this placement and evaluated it very positively. Two students disagreed that they were able to participate in practice, felt part of the team, were challenged to learn
new skills and that the placement met their expectations with one student also disagreeing that staff were aware of her learning needs and that she had achieved the aims and objectives for the placement. One student’s comment illustrates the benefits described by the students: ‘I learned to see midwifery in a new way – less medicalised’. Travel was a problem for 4 students who highlighted the distance from the bus and train station to accommodation.

Four evaluations were received from the practice placements. Overall these were very positive. One area disagreed that the students were keen to participate fully in all aspects of the placement, commenting that they were not keen to work on labour ward ‘possibly from previous experiences’. Another area suggested that the placement be continuous commenting the placement was broken by annual leave. However only certain weeks were available in this placement due to other students being there and a three week continuous placement was not available for this particular student. Overall the placements stated that they enjoyed having the students and commented on their enthusiasm.

### 8.7 Elective placement

A two week elective placement was built into the programme to permit students to study in greater depth a chosen aspect of practice not necessarily included in the programme but applicable to midwifery. It was anticipated that planning an elective placement would also contribute to the development of the midwifery students’ organisational skills. This placement took place from February - May 2002 along with the other external placement – community midwifery, community, and paediatrics. All midwifery students undertook to plan one to two placements. However, they were constrained by the uncertainty regarding the funding for the community midwifery experience and consequently the length of that placement and the effect it would have on the allocation for the period. All placements for that period were finalised barely one week before they commenced. Given the short lead in time the students arranged elective placement that were on the whole to their benefit. Other issues arose in relation to the organisation of this elective placement, for example, obtaining Garda clearance for those students going on placement in the UK, correspondence with the placements etc. Placements requesting Garda clearance were written to stating that it was not practice in the current programme, but stating that clearance would now be sought but could take time. Details of the student’s participation in practice areas to date were also provided. Once the Garda clearance was received the
placement area were written to again with the results of the Garda check even though in all cases the elective placement had been completed. No placement refused to have the students pending clearance.

Table 10 illustrates the variety of placements the midwifery students arranged and completed.

**Table 10  List of elective placements**

<table>
<thead>
<tr>
<th>Elective Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Albany Group Practice, Peckham Pulse, 10 Melton Road, Peckham, London</td>
</tr>
<tr>
<td>2. Albany Group Practice, Peckham Pulse, 10 Melton Road, Peckham, London</td>
</tr>
<tr>
<td>3. Erinville Hospital, Cork</td>
</tr>
<tr>
<td>4. Maternity Unit, Royal – Jubilee Maternity Services, Belfast</td>
</tr>
<tr>
<td>5. Maternity Unit, Wexford General Hospital, Wexford</td>
</tr>
<tr>
<td>6. 1. Social Worker, Social Work Department, The Rotunda Hospital, Dublin</td>
</tr>
<tr>
<td>7. Public Health Nurse, Brookfield Health Centre, Tallaght, Dublin 24</td>
</tr>
<tr>
<td>8. 1. Meath Women’s Refuge, Navan, Co Meath</td>
</tr>
<tr>
<td>9. Lesley Foley, Self-employed midwife, providing community midwifery services</td>
</tr>
<tr>
<td>10. Maternity Services, Darlington Memorial Hospital, Hollyhurst Road, Darlington</td>
</tr>
<tr>
<td>11. Midwifery Led Unit, Craigavon Area Hospital, Portadown, NI</td>
</tr>
<tr>
<td>12. Maternity Unit, Mayo General Hospital, Castlebar, Co Mayo</td>
</tr>
<tr>
<td>13. 1. Mum team, Cardiff</td>
</tr>
<tr>
<td>14. 1. Drogheda Women’s Refuge, Drogheda, Co Louth</td>
</tr>
<tr>
<td>15. Public Health Nurse</td>
</tr>
</tbody>
</table>

The majority of students reported very positive experiences from undertaking this placement. Some comments from the students illustrate the benefits gained:

‘a fantastic experience where I saw underprivileged women and their families given great support, education and information and choice. I saw midwives practising all their skills and providing individualised care for each woman and working very well as part of a team in a supportive environment’

‘I gained an insight into the services provided by my local maternity unit’

‘The PHN in …… was brilliant – amazing relationship with her patients. Very accommodating to me’
‘Brilliant experience – great insight into the effects domestic violence has on the family unit as a whole’.

One student was not positive about a one week placement undertaken in a women’s refuge and where the week was spent with the children rather than the women. The feedback from the placements was also very positive about the students, ‘excellent’ ‘diligent’ ‘highly motivated’. A number of the placements would have liked more communication with the course coordinator, a more formal arrangement put in place rather than the student making contact, and longer placements.

8.8 Discussion and conclusion

The achievement of external placements was for the most part successfully accomplished with two possible exception: placement in the Women’s Refuge and the paediatric placement in Tallaght. Placements with the community midwifery pilot projects, the Drug Liaison Midwives, Our Lady’s Hospital for Sick Children Crumlin, and the elective placement were highly valued by the students. There are a number of issues that need to be considered in relation to the selection and organisation of placements. As already stated a placement with the Public Health Nursing Service is/was considered an essential placements and its achievement for future programmes need pursuing. It was difficult to secure all desirable placements e.g. a community psychiatric placement, because of the competing demands for placements by other programmes. A review of the timing of all placements should be undertaken for future programmes in order to minimise this and ensure that all students are afforded equitable placement experiences.

With regard to the elective placement two issues need to be addressed. First, some of the elective placements were not clear that it was the student’s responsibility to arrange this placement and this was highlighted by the request for more contact with the course coordinator. In response to this it would be worth developing an information leaflet/pack for the midwifery student to give to the placement when first making contact and outlining the student’s responsibilities for the arrangement of the placement. Formal contact can then be made once tentative agreement has been given to provide the placement. Secondly, Garda clearance as part of the selection process should be considered. During the recruitment and selection stage in the development of the is pilot programme, the Department of Health and
Children advised that this was not required as it was not the practice for any other third level student. However, for students going on elective placements to UK or Northern Ireland it is a requirement.

The expenses incurred by students attending external placements needs to be reviewed. As already stated additional funding was secured in order to achieve a community midwifery placement. However some students stated that attending external placements placed an additional financial strain on them. Travel to and from placements and within the placement itself e.g. not being able to accompany the Drug Liaison Midwife in her car when visiting clients/clinics, needs to be addressed. This places additional strain on the students as they use public/their own transport to travel to places they are unfamiliar with and in addition issues such as the frequency of public transport, parking difficulties etc also arise.

8.8.1 Recommendations

Final evaluation:

• Provide a detailed costing of the community midwifery placement;

• Include the evaluation of the medical/surgical placement.

Future programmes:

• Review the timing of external placements so as to minimise competition for placements with other programmes and to avoid large numbers of students in any one placement area;

• Pursue the inclusion of placements with the Public Health Nursing Service;

• Develop the process of communication between the programme (course co-ordinator) and external placements. The production of a booklet with the specific aim of providing external placements with the essential details about the programme and the place that placement has within the programme should be considered;

• Garda clearance as part of the selection process;

• Travelling with a midwife/Public Health Nurse in her/is car.
Chapter Nine

Recruitment, attrition and retention

9.1 Introduction

Given the pilot status of the programme, recruitment and selection are specific to the programme. It was decided that the entry requirements be the same as entry to nursing with the additional requirements necessary for entry to The University of Dublin Trinity College. This chapter details the process of recruitment and selection, and the number of applicants at each stage of that process. A profile of applicants is not provided here. Retention in and attrition from programmes are determinants of the success of a programme. The issues that have been highlighted with regard to these are discussed.

9.2 Recruitment and selection

Twenty (20) places were available on this programme. Advertisements requesting applications for the programme were placed in the national press during the week of 13th February 2000. The Admissions Office, The University of Dublin Trinity College handled enquiries on and applications to the programme. An information booklet was developed and sent to those who made enquiries. It was not possible to keep a record of the number of enquiries in response to the advertisement. However, a print run of 500 information booklets was sent out with a need to then photocopy the booklet. By the closing date of 3rd March 2000, 74 applications had been received. Seventy were eligible to apply and were invited to begin the selection process.

Fifty six applicants who met the minimum entry requirements (similar for entry to nursing) or who qualified as mature students were short listed for interview following the completion of a written academic exercise administered by the School of Psychology, TCD. Those scoring highest in rank order were called for interview. Following the written assessment, applicants were invited to attend an information session regarding the programme. Forty seven candidates attended for interview. Thirty three were successful and were ranked in order of merit according to their performance at the interview. A place on the programme was offered to the first twenty (20) applicants. A reserve panel of successful
applicants (13) was established and places, which were not accepted (4) were filled from this panel. It was not possible to defer the acceptance of an offer of a place due to the nature of this being a pilot programme. Offers of a place on the programme were subject to the applicant passing a medical examination and satisfactory references being provided. Since the beginning of the programme a database is maintained of all enquiries expressing interest in participating in a future programme.

9.3 Attrition

The attrition rate was 25% (5 midwifery students). This occurred in the first year of the programme. Four midwifery students left for personal reasons and one midwifery student did not meet the requirements to progress to the second year of the programme and was therefore discontinued from the programme. In order to establish the reasons for the decision to leave the programme an attempt was made to interview each student. Table 9.1 outlines these details. Although there was no further attrition

<table>
<thead>
<tr>
<th>Withdrawal date</th>
<th>Reasons given</th>
<th>Action Taken</th>
</tr>
</thead>
</table>
| 1. 24th August 2000 | 1. Accommodation difficulties – needing to move  
2. 1st time away from home  
3. Had been offered a place on the Nurse Registration Education Programme in a site close to family home | Investigated availability of accommodation in the residence in the Rotunda – not available |
| 2. 16th January 2001 | Telephone interview  
1. Family commitments regarding childcare  
2. Balancing the intensity of the programme with family life  
3. Financial impact of undertaking the programme and therefore not being able to undertake full-time employment | Contacted Senior Tutor’s office regarding financial assistance to student and passed this information to the student |
| 3. 4th February 2001 | Interviewed  
1. Family commitments  
2. Intensity of the programme and its impact on her personally and her family | None |
| 4. 11th May 2001 | Interview arranged, student unable to attend  
1. Family commitments  
2. Travelling approx. 40 miles each way and did not have own transport  
3. Needed to resubmit assignment | None |
| 5. 31st May 2001 | Required to withdraw as had not met the requirements to proceed to year two of the programme. | None |
from the programme a number of students have indicated at times the difficulty they had in remaining on the programme. The two main difficulties that arose were financial problems and childcare issues.

### 9.4 Retention

Fourteen midwifery students successfully completed the totality of the programme. At the point of the completion of this evaluation, one midwifery is absent on sick leave from the programme. A number of questions were asked to elicit some of the difficulties the students may have experienced being students on the programme. As already stated an information session was held during the selection process. However, just over half the midwifery students (was 77% at the interim) disagreed/strongly disagreed that they had been provided with a realistic view of the programme before it started. The students in the focus group felt that nothing more could have been done to prepare them for something so new to them and, in particular, such a new and original programme that no-one could predict or explain what it would be like.

An annual maintenance grant, plus meal allowance, (€4,444 (£3,500) and from 1st June 2001 €4,773 (£3,759) per annum), which was non-means tested and not subject to income tax, was paid to students during year one and year two of the programme. During year three of the programme, the students were salaried for the period of rostered midwifery practice placements (36 weeks inclusive of 4 weeks annual leave) and received the grant, pro rata, for the remaining 16 week period of that year. Table 9.2 illustrates the level of agreement/disagreement with a number of statements asked regarding students’ need to work to supplement this income. All the respondents considered themselves financially dependent with 40% (n=6) needing to work during holidays and at weekends. Four (27%) students agreed that they needed to work during the week. When asked to describe three things they would change about the programme, six students’ comments related to financial issues, as one student wrote “The money - poverty does not enhance learning”. One midwife teacher commented ‘amount of financial aid – increase it’. However, there was majority agreement amongst midwifery students, midwife managers and teachers that ‘the financial implication for midwifery students undertaking the programme was clear before it started’.
Table 9.2 Financial resources

<table>
<thead>
<tr>
<th>Financial resources</th>
<th>Strongly disagree 1</th>
<th>Disagree 2</th>
<th>Agree 3</th>
<th>Strongly agree 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued on the programme only with the financial help of others</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
</tr>
<tr>
<td>Worked at weekends to supplement income</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13%</td>
<td>47%</td>
<td>13%</td>
</tr>
<tr>
<td>Worked during the week to supplement income</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13%</td>
<td>53%</td>
<td>13%</td>
</tr>
<tr>
<td>Worked during holidays to supplement income</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13%</td>
<td>47%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Transport to practice placements, especially Drogheda, has been identified as an issue that places additional financial strain on students. The majority of midwifery students did not find it easy to travel and their own means of transport was an essential (see Table 9.3). Although public transport will enable students to arrive from Dublin city centre in time for the start of practice shifts, it is not clear if it is would overcome this problem. A number of students have stayed in Drogheda while on placement there but this has been an additional financial burden given that it was not considered an external placement and therefore did not entitle the student to an accommodation allowance of €50.79 per week. Although the majority agreed that staff did not understand the difficulties they had getting to placements, they also agreed that they were able to negotiate shift patterns to suit them possible to do so if one required public transport to the city centre to catch the train. It is definitely not possible to use
public transport on a Sunday/Bank holiday to travel to Drogheda in time for the beginning of an early shift. The hospital is also some distance from the train station. These issues need greater consideration. The provision of accommodation in Drogheda for students while on placement

9.5 Discussion and conclusion

An attrition rate of 25% appears high but this is comparable to the attrition from programmes in England during the initial years (Fraser et al 1997) where the rate ranged from 0 – 45%. During the recruitment stage it is essential to provide potential students with realistic expectations regarding the programme. Although an attempt was made to do this during the recruitment stage for this pilot programme it was not achieved. As this was the first programme it may be unrealistic to suggest that it was possible to provide any more realistic view than that provided and the students in the focus group interview have supported this view. The students did suggest, however, that they could attend a question and answer session with prospective new students to clarify queries with them before the start of the course.

The financial burden and, for those with dependents, care provision are issues not just for this group of students but the total student body. It is an issue that the midwifery profession should seek creative solutions to. It is well documented that the level of support provided for all students to participate in third level education is insufficient without backing from their families. The consequences for the midwifery profession is to continue to perpetuate a situation that only potential students from middle/higher income families will be able to enter the profession. Scholarships, sponsorships etc could be explored as well as support for students faced with sudden, unanticipated financial crises.

9.5.1 Recommendations

• Explore the financial implications of undertaking the programme in order to provide realistic information for students on future programmes;
• Review the issues (travel, cost, time) involved in undertaking placements in two maternity units;
• Develop an information booklet that provides as realistic a picture as to what it means to be a student on a programme of direct entry to midwifery for prospective midwifery students.
10.1 Introduction

This chapter details the funding provided for the set-up, development, delivery and evaluation of the Diploma in Midwifery (Direct Entry) programme. During the development stages it was decided that The Rotunda Hospital would act as fund holder and paymaster with regard to the programme as recorded in the minutes of the Direct Entry to Midwifery Steering Committee meeting of 20th March 2000. This entailed paying student grants, college fees, travel, book and uniform allowances and costs from Trinity College and Our Lady of Lourdes, Louth/Meath Hospital Group, NEHB, Drogheda.

10.2 Set-up costs

A document received at a meeting in February 2002 from the Department of Health and Children details the funding provided in 2000 and 2001 and a break down of the items included in the allocation (Appendix IX). There is one item in relation to estimated set-up costs, a payment of €3,073 (£2,420) to the third level institution. In 2000 the School of Nursing and Midwifery Studies TCD invoiced The Rotunda Hospital and received €3,310 (£2,607) in relation to set-up costs. The Rotunda Hospital received capital funding (not to exceed €279,342 (£220,000)) from the Eastern Regional Health Authority with regard to the refurbishment of the School of Midwifery for, in part, the Direct Entry to Midwifery programme.

10.3 Funding

The funding and expenditure for the programme is detailed in Table ?. Also included is an additional 6 month period i.e. 4 months prior to the commencement of the programme and 2 months following its completion during which this evaluation was undertaken. The total funding provided for the programme was €813,901. There was a shortfall in funding of approximately €79,323 (£63,000) by the end of 2000. In the document from the Department of Health and Children (Appendix ?) this shortfall
is identified as €68,566 (£54,000) and a once off payment was made in this respect in 2001. It would appear that funding for the supernumerary preceptors was not adequate. In the document from the Department (Appendix IX), funding to The Rotunda Hospital is provided for 7 ‘mentors’ for 18 weeks at a cost of €87,612 (£69,000).
### Table #: Funding

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
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<tr>
<td>Incomes (DOH &amp; C)</td>
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<td>219,665</td>
<td>219,665</td>
<td>38,092</td>
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<tr>
<td>Recoup of Shortfall 2000</td>
<td></td>
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<tr>
<td>Additional Funding - Once Off</td>
<td>71,105</td>
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<tr>
<td>Part-Time Lecturer - Once Off</td>
<td>16,506</td>
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<td>Travel &amp; Accommodation</td>
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<tr>
<td>Income B/Fwd Previous Year</td>
<td>76,219</td>
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<tr>
<td><strong>Total Income</strong></td>
<td>215,855</td>
<td>375,842</td>
<td>298,423</td>
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**Expenditure**

<table>
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<tr>
<th>Item</th>
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<th>2001</th>
<th>2002</th>
<th>2003</th>
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<tbody>
<tr>
<td>Expenditure B/Fwd Previous Year</td>
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<td>Grant</td>
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<td>73,243</td>
<td>42,554</td>
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<td>Uniform</td>
<td>3,809</td>
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<td>Books</td>
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<td>Preceptors Allowance (7)</td>
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<tr>
<td>Grant: M Carroll - Salary</td>
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<td>56,618</td>
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<td>Set Up Costs</td>
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<td>Midwifery Teacher (75)</td>
<td>14,582</td>
<td>34,283</td>
<td>34,283</td>
<td>14,284</td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td>9,721</td>
<td>22,855</td>
<td>22,855</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>295,178</td>
<td>299,623</td>
<td>182,341</td>
<td>67,116</td>
</tr>
<tr>
<td>EXPENDITURE / INCOME</td>
<td>-79,323</td>
<td>76,219</td>
<td>116,082</td>
<td>48,966</td>
</tr>
</tbody>
</table>
However, at a meeting of the Direct Entry to Midwifery Steering Committee on 27th January 2000, it was agreed that 13 midwives (9 in The Rotunda Hospital and 4 in Our Lady of Lourdes, Drogheda) would take on the role of supernumerary preceptor for the 18 week preceptorship period. This was funded at basic salary rate, plus 25% in lieu of loss of premium payments and funding for a 40 hour ‘Teaching, Assessing and Learning’ programme was included. However, funding was drawn down for only 10 preceptors for 19 weeks and funding for relief preceptors was carried as part of the service budget.

In 2001, an additional once off payment of €71,105 (£56,000) was made. This was in addition to funding for ongoing expenditure and that made available to cover the short fall in 2000. Following a request from Dr. Begley, funding also was made available for the salary of a 0.5 WTE lecturer for 8 months, €16,505 (£13,000), to assist with the ongoing development of the programme. Funding was also made available to St. James’s Hospital to employ a facilitator for a 10 week period to organise, and support students during, the medical/surgical placement.

In 2002, a request was made to the DOH&C with regard to the ‘community midwifery placement’ and €2,539 was received in respect of that.

During year three of the programme, the midwifery students’ status changed to that of employee and all practice placements were ‘rostered’ placements for which the students received a salary equivalent to that of a third year nursing student. Students completed 36 weeks rostered placement (inclusive of annual leave). During the development to the programme it was agreed that this ‘rostered’ period would be funded totally without considering a replacement factor, i.e. midwifery students for midwives as this was impossible to achieve given there was only one programme. Due to the difficulties recruiting, and subsequently retaining, midwifery students to the Postgraduate Diploma in Midwifery programme, funding was available from salary savings to pay the salaries of rostered ‘direct entry’ midwifery students. ‘Direct entry’ midwifery students were considered at the same level of competency as 2nd year ‘postgraduate diploma’ midwifery students.

10.4 Projected costing for a Bachelor in Science in Midwifery – 4 years Honors Degree Programme
A figure of €8,761 (£6,900) per year per student was the amount agreed as part of the national agreement between the Department of Health and Children and the Conference of Heads of Universities of Ireland in relation to nursing education. This is the funding that is provided to the Third Level Institution in relation to student costs, e.g. salaries, library, student services, overheads, consumables and award ceremonies. In addition, funds were made available to cover capital costs, library set-up costs, equipment, staff education for 4 years, project manager and initial allocations officer. The Health Care Provider is responsible for student support and placement organisation (Clinical Placement Co-ordinators, Allocation Officer), nursing students’ uniform, occupational health prior to placements (i.e. vaccinations, medical clearance) and Garda clearance.

This model of funding is now applied to possible funding for the BScM. A number of expenditures in the Diploma in Midwifery (Direct Entry) (see Table ???) will not be paid in relation to the BScM i.e. students’ grants, book allowance, costs associated with recruitment and selection – advertising (provided that sufficient notice is given to include the programme in the CAO listing), psychological test, legal fees, and the evaluation of the pilot programme. Salaries for the course co-ordinator and midwifery teachers will be covered in the funding to the Third Level Institution and uniform and occupational health will be covered by the Health Care Provider. The remaining additional costs are supernumerary preceptorship, travel and accommodation for external placements, and the facilitator associated with the medical surgical placement.

10.4.1 Supporting ‘direct entry’ midwifery students in practice placements

During year one a preceptor, supernumerary to practice, preceptored two midwifery students for a 18 week period. In addition, supernumerary preceptors were provided with a one week education programme to prepare them for their role. The cost, in total, was €137,562. Projected to 2003-04 this cost will be €161,100. This cost is related only to year one of the programme. For the remainder of the programme, ‘direct entry’ midwifery students were preceptored by midwives as part of their role (not supernumerary) and similar to that provided to ‘postgraduate diploma’ midwifery students. This element of supernumerary preceptorship has been identified as costly. However, as discussed in Chapter 7, it proved invaluable in supporting ‘direct entry’ midwifery students.

Within midwifery education, the appointment of Clinical Placement Co-ordinators (CPCs) has not taken place. In the discussions/consultation surrounding the development of this pilot programme it was felt
that midwives engaged in the delivery of care were in the best possible position to act as preceptors. When compared to the cost of a CPC, supernumerary preceptorship in year one is not as costly as it appears. However, it must be emphasised that the comparison of the two roles is not comparing ‘like with like’ and the comparison is only in relation to costs of student support in the practice environment in its broadest sense. Drennan (2001) identified that the average ratio of CPC to nursing student was 1:23. The cost of employing a CPC is approximately €46,734 at the midpoint in the salary scale (including employer contributions). For 20 students this is calculated at €40,638 per year, giving a cost of €162,553 over a 4 year programme. There is a possible savings in relation to the 1 week educational programme provided for supernumerary preceptors; it is anticipated that this would not be need in the future as all midwives now undertake ‘Teaching, Learning and Assessing’ programmes as a preparation for preceptoring all midwifery students. This would result in a reduction in cost of €16,110 resulting in a cost for supernumerary preceptorship in year one of €144,990. Compared to the fulltime employment of a CPC, supernumerary is cost effective. Given the benefits to both the preceptors and midwifery students identified and discussed in Chapter 7, implementing this model of preceptorship must be given serious consideration.

The support of a facilitator was put in place for the medical/surgical placement. However, students undertook other external placements without this type of support without any compromise to learning. Although this facilitator was highly valued and ensured the organisation and execution of the placement was ‘easy’, it is not envisaged that this would be a necessary expenditure in future programmes.

10.4.2 Rostered period

In order to ensure that the cost of the rostered year is maintained within current allocated funds for midwifery education as a whole, it is recommended that at the beginning of the 3rd year of the new BScM programme there is a reduction in the number of ‘postgraduate diploma’ midwifery students recruited in line with the number of ‘direct entry’ midwifery students that will enter the rostered period. Or alternatively, a reduction in the number of ‘postgraduate diploma’ midwifery students recruited in line with the cost of salaries for ‘direct entry’ midwifery students in the rostered period may be considered. The salary of a third year midwifery (nursing) student is €19,113 per annum compared to €24,102 per annum for a ‘postgraduate diploma’ midwifery student.

10.4.3 External placements
As already stated, additional funding (€2,539) was received to facilitate a ‘community midwifery’ placement. The actual cost of this placement for 11 midwifery students (it was possible to source a placement for 4 students in Dublin) was €5,028. Given some of the recommendations regarding the future direction of maternity services in Ireland (Kinder 2002), it is imperative that midwifery students participate in midwifery led services in both community and hospital settings.

10.5 Discussion and conclusion

It has been suggested that this pilot programme of Direct Entry to Midwifery is expensive when compared to the pre-registration nurse education programme. However, there appears to be a dearth of data in relation to the specific costs of educating nursing students. A figure of €8761 (£6,900) per year per student was the amount agreed as part of the national agreement in relation to nursing education by the National Implementation Body. The element of supernumerary preceptorship in year one has been shown to be similar in cost to the support systems that have been put in place in the nursing pre-registration programme i.e. the role of Clinical Placement Co-ordinator.

It has not been possible to detail all items of the cost of this programme. An attempt has been made to undertake a comparison with similar programmes internationally. However, information is not available for all aspects.

10.5.1 Recommendations

Final evaluation:

- Undertake a detailed exploration of the costs of this programme and compare to other similar programmes nationally and internationally;
- Provide Euro and Punt values for funding and cost figures.
- Cost benefit analysis and economy of scale
- Comparison to other midwifery rather than nursing programmes which by their nature are different globally.
11.1 Recommendations in relation to the final evaluation

- Undertake a comprehensive review of the literature on ‘direct entry’ to midwifery;
- Undertake a review of outcome evaluation of other health professional programmes with emphasis on the first year in practice identifying level of competence and supports needed;
- Use focus group interviews/ interviews to explore issues that emerge during the quantitative data collection stage;
- Explore the adequacy of the structures put in place to develop and deliver the programme;
- Explore the relevance of all practice placements to ‘becoming a midwife’;
- Explore the benefits of practice experience in the two linked maternity units and the aspects that were perceived as a possible hindrance to skill transfer;
- Explore the findings of the evaluation of the preceptorship period in terms of the finding of the final evaluation;
- Provide a detailed costing of the community midwifery placement;
- Include the evaluation of the medical/surgical placement;
- With midwifery students, further explore the issues that made it easy /difficult for them undertaking this programme;
- Undertake a detailed exploration of the costs of this programme and compare to other similar programmes nationally and internationally;
- Provide Euro and Punt values for funding and cost figures.

11.2 Recommendations in relation to future programmes
• Review the structures and processes of communication to ensure that all key stakeholders have the means to keep abreast of the development of the programme and have a forum to voice an opinion(s);
• Consider an increase in the amount of time allocated to ‘independent learning’;
• Review the assessment strategy in year two of the programme;
• Review the structure of the 18 week period to reduce the intensity for the midwifery students and to include an annual leave allocation;
• The concept of midwifery students as supernumerary should be reviewed and consideration given to the inclusion of independent learning time (especially in year one of the programme) in order to maximise learning while in practice placements;
• Consider a change of preceptor and midwifery student partner midway in the preceptorship period;
• Review the programme content to include the following content: giving and receiving constructive feedback, managing difficult relationships, assertiveness skills, working in a team;
• Review the timing of external placements so as to minimise competition for placements with other programmes and to avoid large numbers of students in any one placement area;
• Pursue the inclusion of placements with the Public Health Nursing Service;
• Develop the process of communication between the programme (course co-ordinator) and external placements. The production of a booklet with the specific aim of providing external placements with the essential details about the programme and the place that placement has within the programme should be considered;
• Garda clearance as part of the selection process;
• Travelling with a midwife/Public Health Nurse in her/is car;
• Explore the financial implications of undertaking the programme in order to provide realistic information for students on future programmes;
• Review the issues (travel, cost, time) involved in undertaking placements in two maternity units;
• Based on the issues highlighted by the students, develop an information booklet that provides as realistic a picture as to what it means to be a student on a programme of direct entry to midwifery for the next cohort of midwifery students.