3 1 AUG

My name is Carol McIntyre and I have practiced as a Maternal and child Health nurse in Victoria for 4 1/2ys. I have worked for Wyndham city in various centres during that period.

I am registered as a midwife with the Australian Health Regulation Authority. I completed my certificate of nursing in 1979 after training at Colac District Hospital. I completed midwifery training at Royal Womens Hospital in 1982. Additionally, I completed Post graduate Diploma in child, Family and Community Nursing Science at La Trobe University in 2006.

My submission is limited to Chapter 12.3 of the Early Childhood Development Draft report, and the "child health workforce".

I am particularly concerned with recommendation 12.3 of the Draft report regarding the removal of midwifery as a qualification prerequisite for MCH nurses. I believe this would greatly reduce the quality of the Victorian MCH nursing service, which in no small part is due to the robust qualification requirements and educational preparation of Victorian MCH nurses.

I am strongly opposed to removal of midwifery as a qualification prerequisite for MCH nurses and believe that my qualification in midwifery has given me a critical body of knowledge and invaluable professional skills to practice as a MCH nurse

In my everyday practice I frequently draw upon my midwifery knowledge and experience in providing quality MCH nursing care and where clients care may have suffered had I not obtained this qualification.

For example on Tuesday 16/08/11 I visited 2 families in routine home visits. In discussion with the first woman, she explained that her perineum was still very sore even though she was 8 days post delivery. When I examined her, I noted that her episiotomy had broken down and advised her to attend her local doctor as soon as possible.

In reading the Birth Outcome Discharge Summary of the second woman I noted that her blood loss was documented as 800mls, Due to my midwifery training I realized that this amount of blood loss constitutes a post partum haemorrhage. This was not documented as such. A blood loss of this amount can cause anaemia depending on the woman's base haemaglobin levels. This had not been discussed with her prior to hospital discharge. She was pale and tired, and struggling to produce enough breast milk for her infant. Iron supplements, diet and extra family supports were discussed.

The requirement to be a midwife has not been a barrier for me to practice as an MCH nurse but rather has been an essential qualification that informs my everyday practice as an MCH nurse. I also believe it is critically important that MCH nurses be registered nurses. The knowledge gained through my nursing training has provided me a strong foundation to use in my everyday MCH practice. For example, caring for a babe with a cardiac abnormality. I worked as part of a larger team weighing the babe at regular

intervals and monitoring growth, feeding and general health in between Cardiologist's visits. On one such visit to the centre, I noted the babe's breathing to be more laboured than in previous visits and advised her to seek a review urgently. The cardiologist reviewed the babe and medication had to be increased to stabilize the babe.

Another example, a mother who was feeling depressed and rundown trying to cope with 2 small children, had a family history of thyroid issues .With my understanding of hypothyroidism in mind, I suggested she make an appointment with her GP and request a thyroid function test. This she did and was found to be suffering from hypothyroidism and with the appropriate medication she is able to care for her children more adequately.

Finally it is vitally important that MCH nurses complete a post graduate MCH program of study. This additional study has provided me with the necessary knowledge and understanding to provide holistic and family centered MCH nursing care in the community setting. Foe example, the mother of two young children, 2ys and 4months. who with her partner has recently moved in to the area. She presented with concerns about her toddlers behaviour. In discussion while the behaviour appeared age appropriate, the mother was having difficulty cope with this. An Edinburgh Post natal depression Score of 15 showed a level of Post natal depression. I discussed seeing her GP, but also linked her in with local playgroups and pram walking groups to build social connectedness and start to rebuild her social support.

Another example is of a family with a four year old with probable global developmental delay. They had been attending various appointments with health professionals in order to have a definitive diagnosis. I was able to link them in with a MY time playgroup which is run in conjunction with the Community health service. This allowed the child to play and interact with other children with health professionals overseeing him and guiding his activity and allowed for the parents to interact with other parents in similar situations.

I strongly believe the requirement to be a midwife, registered nurse and to have undertaken MCH post graduate program of study are critical to my ability to provide quality MCH nursing care. Processing such qualifications should not be seen negatively as a barrier to MCH nursing but rather the cornerstone of providing MCH nursing care.

I am very concerned at the limited consultation undertaken by the Productivity Commission with Victorian nurses. Our service is widely considered to be the best in Australia and has much strength. It is therefore surprising to me that the commission has not held Public Sittings with Victorian MCH nurses. To help understand the many strengths of the Victorian MCH Framework, I would be grateful if the Commission would meet with me and other MCH nursing colleagues.

I thank the commission for considering my comments.

I hope that the far reaching strengths of the Victorian MCH nursing service can be adopted by other states and that recommendations are not imposed that reduce and diminish the quality of the Victorian nursing service.

While I value the role that practice nurses play in the general practice setting, I am concerned at the suggestion that the substantial number of child health nurses working in general practice could therefore be thought of as a reserve pool of child health nurses. I am unaware of any statistics regarding this so would be interested to know where these figures where found.

I am aware of a great number of highly qualified practice nurses, particularly those who work within specialized fields. However there is no accredited or standardized training for practice nurses .and their qualifications can range from registered to enrolled nurses depending on the practice. Because of this , I do not believe that practice nurses are suitable substitute fort the Maternal and Child health workforce and I believe the suggestion underestimates the complexity of the Maternal and Health nursing role

. I have recently had two contacts with practice nurses from my local area.

The first practice nurse rang my centre after being asked by the GP to complete a four year old developmental check. She had recently joined the practice; she was a Division 1 registered nurse who had been working in an endoscopy facility so her experience was in operating theatres. She only had the experience of her 2 yr old nephew to base her understanding of the developmental guidelines that this 4 yr old should be meeting. The practice did not have the equipment for a vision testing of a child. Luckily this was a bright boy who could tell her the letters on the chart. Many would not have been able to do this.

The second incident was a direct entry midwifery student who came to the centre for information; she is currently working as a practice nurse. She currently holds a division 2 nursing registration. She was discussing immunizations. She was required to immunize babies and toddlers but was unsure that she was using the correct technique. She had little training but had been assured was covered as she was under the guidance of the Division 1 practice nurse even if that practice nurse was not working the same shift.

I believe that removing the maternal health aspect from our role and talking only of Child Health Nursing is simplistic. The whole family is responsible for raising happy, well adjusted children who can meet their potential. Our holistic approach to caring for the mother and the family is vital to a childs health and well being.