MPOP

UNM Midwifery Preceptor Orientation Program

Manual of Resources

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AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime™

CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE

The *Core Competencies for Basic Midwifery Practice* include the fundamental knowledge, skills, and behaviors expected of a new practitioner. Accordingly, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited/preaccredited by the Accreditation Commission for Midwifery Education (ACME), formerly the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA).

Midwifery practice is based on the *Core Competencies for Basic Midwifery Practice*, the *Standards for the Practice of Midwifery,* the *Philosophy of the ACNM,* and the *Code of Ethics* promulgated by the ACNM. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the ACNM or the American Midwifery Certification Board (AMCB), formerly the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary health care providers for women and newborns.

The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives may choose to expand their practice following the guidelines outlined in Standard VIII of the *Standards for the Practice of Midwifery.*

Midwifery education is based on an understanding of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. Midwives provide health care that incorporates appropriate medical consultation, collaborative management, or referral. Each education program is encouraged to develop its own method of addressing health care issues beyond the scope of the current core competencies, and each graduate is responsible for complying with the laws of the jurisdiction where midwifery is practiced and the ACNM *Standards for the Practice of Midwifery.*

ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report, *Primary Care: America's Health Care in a New Era,*[1] the *Philosophy of the ACNM,*[2] and the ACNM position statement, "Midwives are Primary Care Providers and Leaders of Maternity Care Homes."[3] Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. As primary health care providers, CNMs and CMs assume responsibility for the provision of and referral to appropriate health care services, including prescribing, administering and dispensing of pharmacologic agents. The concepts, skills, and midwifery management processes identified

K. Participation in self-evaluation, peer review, lifelong learning, and other activities that ensure and validate quality practice
L. Development of leadership skills
M. Knowledge of licensure, clinical privileges, and credentialing

N. Knowledge of practice management and finances
O. Promotion of the profession of midwifery, including participation in the professional organization at the local and national level
P. Support of the profession's growth through participation in midwifery education
Q. Knowledge of the structure and function of ACNM

III. Components of Midwifery Care: Midwifery Management Process

The midwifery management process is used for all areas of clinical care and consists of the following steps:

A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or referral with other health care team members as dictated by the condition of the woman, fetus, or newborn.
E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and includes therapeutics as indicated.
F. Assume responsibility for the safe and efficient implementation of a plan of care that includes the provision of treatments and interventions as indicated.
G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

IV. Components of Midwifery Care: Fundamentals

A. Anatomy and physiology, including pathophysiology
B. Normal growth and development
C. Psychosocial, sexual, and behavioral development
D. Basic epidemiology
E. Nutrition
F. Pharmacokinetics and pharmacotherapeutics
G. Principles of individual and group health education
H. Bioethics related to the care of women, newborns, and families
I. Clinical genetics and genomics

1. Human sexuality, including biological sex, gender identities and roles, sexual orientation, eroticism, intimacy, and reproduction
2. Common screening tools and diagnostic tests
3. Common gynecologic and urogynecologic problems
4. All available contraceptive methods
5. Sexually transmitted infections including indicated partner evaluation, treatment, or referral
6. Counseling for sexual behaviors that promote health and prevent disease
7. Counseling, clinical interventions, and/or referral for unplanned or undesired pregnancies, sexual and gender concerns, and infertility
8. Identification of deviations from normal and appropriate interventions, including management of complications and emergencies utilizing consultation, collaboration, and/or referral as indicated

D. Applies knowledge, skills, and abilities in the perimenopausal and postmenopausal periods that include but are not limited to the following:

1. Effects of menopause on physical, mental, and sexual health
2. Identification of deviations from normal
3. Counseling and education for health maintenance and promotion
4. Initiation or referral for age/risk appropriate periodic health screening
5. Management and therapeutics for alleviation of common discomforts

E. Applies knowledge, skills and abilities in the antepartum period that include but are not limited to the following:

1. Epidemiology of maternal and perinatal morbidity and mortality
2. Confirmation and dating of pregnancy
3. Promotion of normal pregnancy using management strategies and therapeutics as indicated
4. Common discomforts of pregnancy
5. Influence of environmental, cultural and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
6. Health risks, including but not limited to domestic violence, infections, and substance use/abuse
7. Emotional, psychosocial, and sexual changes during pregnancy
8. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation
9. Deviations from normal and appropriate interventions, including management of complications and emergencies
10. Placental physiology, embryology, fetal development, and indicators of fetal well-being

F. Applies knowledge, skills, and abilities in the intrapartum period that include but are not limited to the following:

a. Establishment of respiration
b. Cardiac and hematologic stabilization including cord clamping and cutting
c. Thermoregulation
d. Establishment of feeding and maintenance of normoglycemia
e. Bonding and attachment through prolonged contact with neonate.
f. Identification of deviations from normal and their management.
g. Emergency management including resuscitation, stabilization, and consultation and referral as needed

4. Evaluation of the newborn:
    a. Initial physical and behavioral assessment for term and preterm infants
    b. Gestational age assessment
    c. Ongoing assessment and management for term, well newborns during first 28 days
    d. Identification of deviations from normal and consultation, and/or referral to appropriate health services as indicated
5. Develops a plan in conjunction with the woman and family for care of the newborn for the first 28 days of life, including nationally defined goals and objectives for health promotion and disease prevention:
    a. Teaching regarding normal behaviors and development to promote attachment
    b. Feeding and weight gain including management of common breastfeeding problems
    c. Normal daily care, interaction, and activity including sleep practice and creating a safe environment
    d. Provision of preventative care that includes but is not limited to
        (1) Therapeutics including eye ointment, vitamin K, and others as appropriate by local or national guidelines
        (2) Testing and screening according to local and national guidelines
        (3) Need for ongoing preventative health care with pediatric care providers
    e. Safe integration of the newborn into the family and cultural unit
    f. Appropriate interventions and referrals for abnormal conditions:
        (1) Minor and severe congenital malformations
        (2) Poor transition to extrauterine life
        (3) Symptoms of infection
        (4) Infants born to mothers with infections
        (5) Postpartum depression and its effect on the newborn
        (6) End-of-life care for stillbirth and conditions incompatible with life
    g. Health education specific to the infant and woman's needs:
        (1) Care of multiple children including siblings and multiple births
        (2) Available community resources

UNM COLLEGE OF NURSING

Resources for Clinical Educators

Looking for more training to be a better clinical educator? Here are some resources we have found to get you started.

FREE RESOURCES

1) UNM College of Nursing PowerPoint presentation, "Preceptor Power and Influence: Transforming Student Learning" created by Carolyn Montoya, PhD, CPNP and Robyn Mintz, Senior Program Manager. Email HSC-CON-Placements@salud.unm.edu for a copy.

2) Frontier Nursing University has developed a series of brief videos discussing techniques for working with advanced practice nursing students. You do not need to register as a preceptor for them to view the modules. (You can skip module six, which is all about FNUs processes.)
https://portal.frontier.edu/web/fnu/gift-of-precepting

3) National Organization of Nurse Practitioner Faculties Preceptor Portal contains good videos demonstrating working one on one with students. Working with difficult student issues is addressed. Techniques could also be used when working with undergraduate students in the clinical area.
http://www.nonpf.org/?page=PreceptorPortal_Main

4) The Academic Clinical Nursing Instructor Preparation Course is a great resource for the BSN clinical teacher. The course is free, and it is evidence based. Mentorship with an experienced clinical teacher is included. REQUIRES REGISTRATION.
http://knowlessk.wix.com/nurse-educator

5) The University Of New Mexico College Of Nursing Certified Nurse Midwifery Program produced a recording of a 2+ hour preceptor training session held several years ago.
http://nursing.unm.edu/evaluation.html

6) The University of Texas-at Austin offers a free online learning module for clinical instructors at all levels.
https://nursing.utexas.edu/docs/faculty/preceptorsTraining.pdf

7) A brief recap of our keynote on RESPECT can be obtained from this Camara Jones TED Talk.
https://www.youtube.com/watch?v=GNhcY6fTyBM

HEALTH SCIENCES
COLLEGE OF NURSING

Typhon Tips for Preceptors

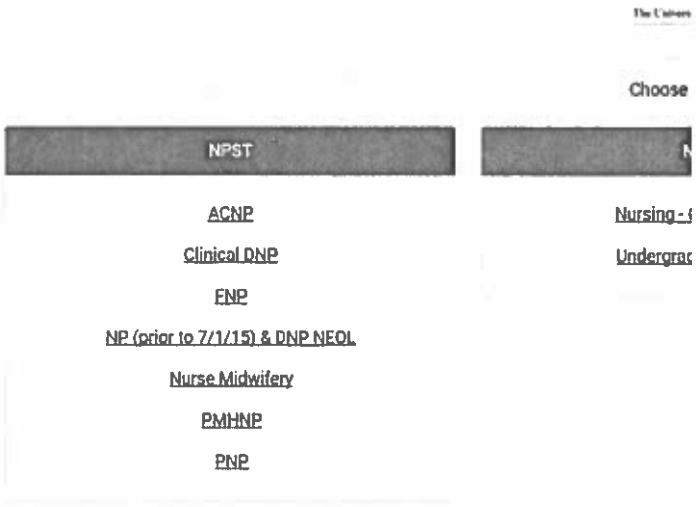
LOGIN as a PRECEPTOR

Below is a link to the general login page.

Note: If you serve as both a preceptor and a site visitor, you will have more than one Typhon account. Preceptor accounts and Sub-Administrator accounts have different permissions. Be sure to log into your **preceptor** account.

Here is the link: https://www.typhongroup.net/unm/

- The link will bring you to the following screen where you can choose the correct program:



- Once you choose the program you will be brought to the following screen where you will choose "Preceptor/EASI Login"

PRECEPTOR HOME SCREEN

The Home Screen is where you will find all the links you need to perform tasks, including the following:

- How to find the student's contact information.
- How to find preceptor documents.
- How to find additional helpful instructions in the Typhon system.

(Refer to this image for all remaining instructions)

QUESTIONS? General instructions are below, but specific questions can be directed to the UNM Coll

EVALUATIONS & SURVEYS

The following evaluations and surveys can be completed by you. Click on a link to begin:

There are no evaluations or surveys set up or open at this time.
If you were told to complete an evaluation, ask your program administrator to make sure they opened the evaluation to respondents.

STUDENT REPORTS

Case Log Details
View the details of each patient encounter where students entered you as the supervisor

Case Log Highlights
View a summary list of patient encounters where students entered you as the supervisor

Time Logs
Review and approve student's shift time each day where students entered you as the supervisor

YOUR SCHEDULE

View Schedule of Events
View all of your events in a chronological list or in calendar format. These events are entered by the program and usually include your schedule with students.

ACCOUNT INFORMATION

Edit Your Information
Edit certain personal information that is stored in the system for you

SCHOOL DOCUMENTS

Download Documents/Instructions
Download documents that the school has posted for supervisors

HELP TOPICS

Instructions
Instructions for using the Typhon Group system

HOW TO FIND PRECEPTOR DOCUMENTS

- From the Home Screen, find the section titled "School Documents" (See red arrow on page 3). Click on the "Download Documents/Instructions" link and you will brought to the following screen: (**NOTE:** Documents may vary according to program)

DOWNLOAD DOCUMENTS/INSTRUCTIONS

The following documents have been made available by the school for all preceptors to view. They can be downloaded to your computer and used as need that column.

Category	Description
Evaluations	N535 1st Clinical Rotation Preceptor Evaluation of Student
Fall 2017 Clinical Rotation	Fall 2017 Clinical Rotation Guidelines
Fall 2017 Clinical Rotation	N537 Primary Care of Adults III Syllabus
Fall 2017 Clinical Rotation	N546 Primary Care Pediatrics II Syllabus
Preceptor Forms	APRN Data Form
Preceptor Forms	MD/PA Data Form
Preceptor Forms	Preceptor Benefits Request Form
Preceptor Training	Resource List

- Click on the document you want to open.
- **NOTE:** You will find different types of documents ranging from preceptor benefits information to rotation guidelines and syllabi.

email system, can send a request to HSC-CON-Placements@salud.unm.edu to register their email address with the Cisco Registered Envelope Service (CRES). Communication also can be sent to the CON's secure fax address at (505) 272-5280. Please be sure to attach a cover page when faxing.

Preceptor and Facility Information: The CON's accrediting agencies require specific data about its preceptors and clinical sites in order to ensure clinical placements are providing appropriate learning experiences for the students. An accreditation site visit is anticipated in the spring of 2020. Preceptors can help the CON fulfill its obligations by completing and submitting the appropriate APRN or MD/PA Data form provided in Typhon School Documents.

Preceptor Professional Development: The CON has developed a series of online continuing education modules. They cover a variety of themes, including preceptor skills, cultural perspectives, and clinical topics. First-time preceptors are encouraged to review the module, *The Clinician as Teacher: Strategies for Preceptors*. All of the CE offerings are CME approved through the UNM School of Medicine CME office. They can be accessed in the Typhon system and are self-paced for your convenience. The American College of Nurse-Midwives website offers preceptor resources as well at http://www.midwife.org/Preceptors .

Preceptor Benefits: In recognition of their service, preceptors are eligible for a Volunteer Adjunct Faculty appointment. An explanation of the benefits associated with the appointment can be found on the Benefits Request form, which is uploaded in Typhon School Documents. Preceptors who would like to participate or renew their benefits should submit a completed form and their CV to *HSC-CON-Placements@salud.unm.edu*.

Contacts: Please direct questions or comments concerning the preceptorship to:

Kristen Ostrem, DNP, CFNP, CNM
Nurse-Midwifery Concentration Coordinator
Director of MSN Programs
Office: (505) 272-9630
Cell: (505) 400-1024
kostrem@salud.unm.edu

Robyn Mintz
Senior Program Manager
(505) 272-1184
rmintz@salud.unm.edu

Additional Resources:

1. Further information about the Nurse-Midwifery Concentration can be found on the CON's website at https://hsc.unm.edu/college-of-nursing/education/msn/nurse-midwifery.html and in the *Nurse-Midwifery Manual for 2018-2019,* which is posted in Typhon under Program Resources.

UNM
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ADVANCED PRACTICE REGISTERED NURSE DATA FORM

Preceptor Information: (Please print)

Name: _____ Date :_____

Credentials: _____

Preferred Mailing Address:

_____
(Address)

_____
(City) (State) (Zip)

Contact Info: *(Will be available to CON administration and students)*

Primary Email: _____

Office Phone: _____ Mobile Phone: _____ Pager: _____

Select the national certification association/board you are certified by (if applicable):

☐ ANCC ☐ AANP ☐ PNCB ☐ AACN ☐ AMCB

Educational Background and Experience:

Nursing degrees (Check all that apply): ☐ ADN ☐ BSN ☐ MSN ☐ DNP ☐ PhD

UNM CON degrees (Check all that apply): ☐ FNP ☐ PNP ☐ AG-ACNP ☐ CNM ☐ Admin ☐ DNP
☐ Other _____

Specialty areas: _____

Years of practice in your population focused/specialty area(s): _____

Years with current organization: _____

Have you taught advanced practice nursing students in a preceptor role in the past? ☐ Yes ☐ No

Facility Information:

Facility Name: _____

Physical Address: _____

Business Phone: _____ Business Fax: _____

Facility Demographics:

Facility Type: (Check all that apply) ☐ Primary Care ☐ Urgent Care ☐ Inpatient ☐ Long Term Acute Care
☐ Private Practice ☐ Rural Clinic

Populations Served: (Check all that apply) ☐ Newborns ☐ Infants ☐ Children ☐ Adolescents
☐ Adults ☐ Women ☐ Geriatrics (Age 65 and older)

Number of beds and/or exam rooms: _____

Roles and Responsibilities:

Did you receive course and clinical objectives (written or verbal)? ☐ Yes ☐ No

Did you receive orientation (written or verbal) for your role as preceptor? ☐ Yes ☐ No

What additional assistance would be beneficial to support and enhance your role as a preceptor?

_____

_____

RETURN COMPLETED FORM TO:
HSC-CON-Placements@salud.unm.edu

COLLEGE OF NURSING

BENEFITS REQUEST FORM
APRN and DNP PRECEPTORS

Thank you for supporting nursing education! In recognition of your service as a preceptor, you are invited to take advantage of the Adjunct Faculty Appointment benefits package by completing the bottom of this form and submitting it along with your Data Form. Preceptors wishing to add or renew benefits must submit a new form.

Adjunct Faculty Appointment Benefits Package. Preceptors will be eligible for Adjunct Faculty appointments after having met the following requirements:

- served for one rotation, practice intensive or practicum for a minimum of 50 hours;
- submitted a current College of Nursing Data Form and CV;
- maintained responsibility for direct supervision of the student;
- completed required College of Nursing evaluations;
- been formally reviewed by the student and, when applicable, the site visitor or faculty of record using the College of Nursing's (CON's) evaluation tools.

The appointment will be valid for one year. Requests for renewal will be considered for providers who commit to continued service. Consideration also will be given to co-preceptors who do not have primary supervisory responsibilities if they have precepted for more than 50 hours during a term or an academic year.

An Adjunct Faculty Appointment includes the following benefits and access:

- **UNM libraries, including the Health Sciences & Informatics Library (HSLIC):** UNM libraries is the largest academic library system in the state. You will have remote access to their databases, including UpToDate; PubMed; ejournals; and ebooks. For further details, visit www.unm.edu/libraries/.
- **Online CE Modules:** Self-paced and CME approved, modules cover topics on preceptor and clinical skills development.
- **UNM's Learning Central:** Online platform for UNM-related training and professional development modules.
- **UNM Recreational Services:** Discounted membership on fitness, wellness, and recreational activities for $40 per semester. A one-time $10.00 charge will be applied for all **new or dropped** Rec Card memberships. Learn more about the facilities and available services at http://recsvcs.unm.edu/index.html.
- **Dell Computer Discount:** Special savings of up to 12% on laptops, desktops, printers and other electronics.
- **HSC email address**

☐ **I am requesting a one-year Adjunct Faculty Appointment.** (Please attach a current CV and Data Form.)

I would also like to request the following benefits: (Check all that apply.)

☐ **Library Remote Access**
☐ **Online CE Modules**
☐ **UNM Recreational Services Discounted Membership**
☐ **Dell Computer Discount**
☐ **Learning Central**

QUESTIONS? Email Robyn Mintz at rmintz@salud.unm.edu
RETURN THIS FORM VIA:
Email: HSC-CON-Placements@salud.unm.edu
Fax: 505-272-5280

Name: _____ Credentials: _____

Social Security #: _____ DOB: _____ Phone #: _____

E-mail: _____

Family Educational Rights and Privacy Act of 1974 (FERPA)
Top Ten Things to Know About FERPA

10. The purpose of the Family Educational Rights and Privacy Act of 1974 (FERPA) is to afford certain rights to students concerning their educational records. The primary rights afforded are; the right to inspect and review educational records, the right to seek to have the records amended, and the right to have some control over the disclosure of information from the records.

    Who is a student? Current and former students. **NOT** parents, spouses, or applicants.
    What is an educational record? Any form directly related to the student, maintained by the institution, in whatever media.
    Why do we comply? To protect the student!

9. UNM has designated certain items as directory information. (This is information that can be given out to any requestor, provided that a restriction has not been placed on the individual's record.)

    What is directory information? ***At UNM***, it consists of; name, address, telephone listing, electronic mail address, ****date of birth****, major, dates of attendance, degrees and awards received, most recent educational agency or institution attended, participation in officially recognized activities and sports. What is defined as directory information will vary from school to school but it cannot include SSN, student schedules, or other strictly private information.

8. UNM policies on FERPA, the release of directory information, or how to restrict one's directory information can be found in the student handbook, The Pathfinder at *www.unm.edu/~sac/pathfind.html.*

7. If a student has completed a UNM Student Information Release form restricting the release of directory information, it will be flagged in the Banner screens and LoboWeb listings with a "**CONFIDENTIAL**" notation, this is the ***Confidential Indicator***. Absolutely **NO** information can be released without consent if the Confidential Indicator has been set. If someone is calling for information you must say **"There is no information available on that person, please have him or her contact us directly."**

    How do students set their ***Confidential Indicator?*** By coming to the Registrar's Office. This is an all or nothing Indicator, if it is set we cannot release **ANY** information about the student, including their attendance or graduation status.

6. Grades may not be posted by social security or UNM ID number, in whole or part, because an alphabetical order class list could easily be used to link name and number.

5. "School officials" ***at UNM*** are defined as those members of the institution who act in the student's educational interest within the limitation of their "need to know" to

Student Policies
University Midwifery Associates

Welcome to University Midwifery Associates. We are happy to have you for this clinical experience. This is an extremely important time for learning and we want to help you to have the best experience possible. Beth Tarrant is the Education Coordinator for the service. She is responsible for supporting you in your clinical experience by assisting with communication among you and your preceptors and your faculty liason. She will also take care of scheduling and administrative issues.

We are dedicated to providing high quality midwifery care and to educating nurse-midwives. The following guidelines are provided to help foster a clear understanding of our expectations of you. We will be firm in upholding these guidelines in order to assure the highest quality care for women and families and to encourage your professional development.

- Please communicate honestly with preceptors, other staff and clients. Active listening and open communication are essential to midwifery care and midwifery education. You are expected to be receptive to feedback. You are expected to be respectful in all interactions with preceptors and other team members even when in conflict or addressing difficult issues.

- You will receive a copy of our practice guidelines when you arrive. You are expected to be familiar with these guidelines when you see patients in the clinical setting and to use them in developing your management plans.

- You are to arrive in a timely fashion for every clinical session. Allow time for chart review at the beginning of a session and for charting and conferencing at the end. Do not expect that the session will end on time – all patient care and charting must be completed.

- Always have with you your ID badge, lab coat, pregnancy wheel/app, a pen, stethascope and any other materials you will need.

- You are expected to present a neat and professional appearance whenever you are in a patient care area.

- No patient is to ever leave the office or hospital prior to your consulting with the CNM regarding the management plan and the CNM having appropriate patient contact. We recommend that you do not state the plan until you are sure we will agree. At births, no vaginal exam, procedure, change in management plan, medication or other intervention will occur prior to consultation with the CNM.

PREVIEW ONLY

CNM Faculty Liaison Preceptor Evaluation
Completed by the **Sub-Administrators**, regarding the **Preceptors** , answered on a **As needed** basis.
Before beginning an evaluation, the sub-administrators will be asked to select which preceptor they are evaluating.

1 Please provide the following information:

Name of Clinical Site:
Date of Site Visit (mm/dd/yyyy):
Number of hours the preceptor worked with faculty:
(ANSWER REQUIRED FOR EACH OPTION)

2 Has the preceptor been in practice more than a year?

- ○ Yes
- ○ No

(ANSWER REQUIRED)

3 **DIRECTIONS: Select the rating you feel best describes your experience and provide detailed narrative in the comment section. A comment is required if the rating is less than or equal to "*Undecided*."**

4 The preceptor provided adequate supervision to the student.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided
- ☐ Agree
- ☐ Strongly Agree
- ☐ Additional Comment:

(ANSWER REQUIRED)

5 The preceptor allowed the student to gradually assume responsibilities for carrying out all components of care, management, and teaching.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided
- ☐ Agree
- ☐ Strongly Agree
- ☐ Additional Comment:

(ANSWER REQUIRED)

6 The preceptor helped the student achieve his/her learning goals.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

(ANSWER REQUIRED)

11 I would recommend this preceptor to lead future nurse-midwifery student clinical experiences.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided
- ☐ Agree
- ☐ Strongly Agree
- ☐ Additional Comment:

(ANSWER REQUIRED)

12 **ELECTRONIC SIGNATURE OF THE SUB-ADMINISTRATOR**

"I have reviewed the responses on this form and attest to this by entering my password below."

Typhon Group password of the Sub-Administrator:

Comments from the Sub-Administrator (Optional):

(SIGNATURE PASSWORD REQUIRED)

Preview Submit (Results NOT Saved)

PREVIEW ONLY

NURSE-MIDWIFERY SERVICE MODEL IN AN ACADEMIC ENVIRONMENT

Kay D. Sedler, CNM, MN, Mona Lydon-Rochelle, CNM, MSN, Yvonne M. Castillo, CNM, MS, Ellen C. Craig, CNM, MS, Nancy Clark, CNM, PhD, and Leah Albers, CNM, DrPH

ABSTRACT

This article discusses the development and unique features of a nurse-midwifery division within a university school of medicine department of obstetrics and gynecology and its expanded scope of activities in nurse-midwifery education and research.

Nurse-midwifery has deep roots in New Mexico. The Catholic Maternity Institute in Santa Fe was an early nurse-midwifery education site from 1945 to 1970, and the American College of Nurse-Midwives was first incorporated in New Mexico in 1955. Certified nurse-midwives (CNMs) now deliver every ninth New Mexico baby, one of the highest proportions in the nation. For over 20 years, CNMs have been active in Albuquerque, the state's largest city. For nearly as long, CNMs have been affiliated in some manner with the Department of Obstetrics and Gynecology at the University of New Mexico (UNM) and the University Hospital (UH) in Albuquerque, the only facility of its kind in the state. In recent years, the CNM service at UNM has dramatically expanded in size as well as scope of activities. In this article, we wish to describe these developments in the hope that aspects of our own evolution may be useful to CNMs in similar professional circumstances. We invite dialogue with interested CNMs for sharing of information and for dissemination of additional detail precluded here by space considerations.

Address correspondence to Kay D. Sedler, CNM, MN, Nurse-Midwifery Division, University of New Mexico, 2211 Lomas Boulevard, NE, ACC-4, Albuquerque, NM 87131-5286.

THE CNM SERVICE

Since 1986, the structure of the Department of Obstetrics and Gynecology of the UNM School of Medicine has included six divisions, each with a chief who reports directly to the Department Chair. One of these is the Nurse-Midwifery Division. The Nurse-Midwifery Division Chief has faculty status in the department and sits on various policy-making committees, such as Ambulatory Care and Practice Plan, and participates in resident evaluations. Other staff CNMs participate in department committees such as Research Committee, Student Education, and Quality Improvement. The Nurse-Midwifery Division Chief has private office space and full-time secretarial assistance for division activities. Her time is equally divided between administrative duties (scheduling, departmental functions, hospital activities, long-range planning, and problem solving) and clinical responsibilities.

The Department of Obstetrics and Gynecology provides primary and specialty care clinics at UH. A full range of women's health services are also provided at a variety of sites in the Albuquerque area, some under contractual agreements. These include the Kirtland Air Force Base (KAFB) clinic, the Albuquerque Indian Health Service (IHS) hospital, five federally funded Maternity and Infant Care (M&I) clinics that serve economically disadvantaged women, and several family health centers. Five clinics are designated CNM sites: KAFB, the Albuquerque IHS hospital, one of the M&I clinics, one of the family health

0091-2182/93/$6.00

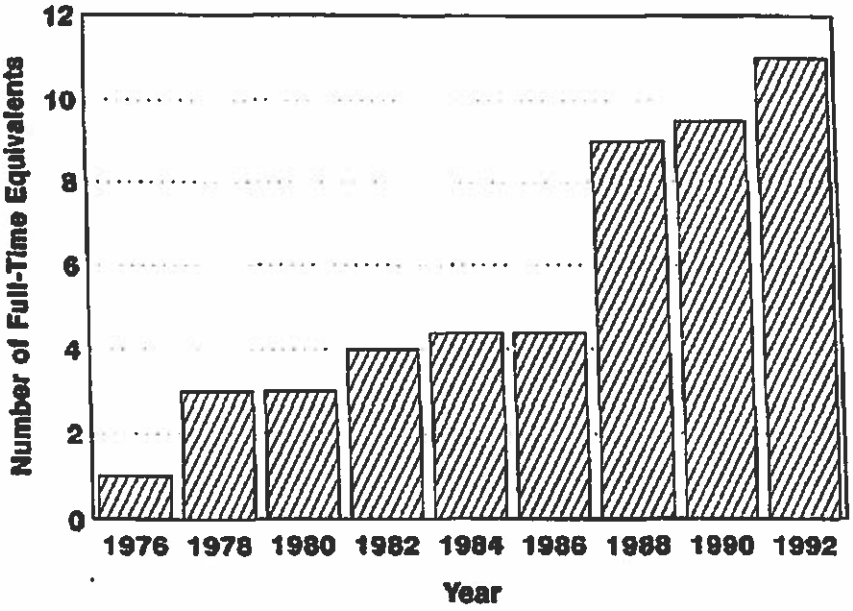

FIGURE 1.
Growth of Nurse-Midwifery Division by full-time equivalents.

students and new interns often have their first deliveries with the CNM service, where the focus is on management of normal labor. The Division's education coordinator works out all scheduling and support functions to accomplish these activities.

The CNM service also has strong commitments to nurse-midwifery education. For several years, integration students from a variety of education programs have come to the UNM service with all arrangements handled by the education coordinator. In 1990–1991, the service precepted the first student to complete CNEP nationally and also provided clinical learning opportunities for the last basic Frontier Nursing Service (FNS) class that was located at UNM. With the advent of the master's-level nurse-midwifery education program at the UNM College of Nursing in January 1992, the service has assumed a wider range of functions to support the education program under direction of the education coordinator. In addition to the traditional functions of precepting students in the clinical areas, the service has also undertaken the screening and interviewing of prospective students, outreach student recruitment activities (particularly in underserved areas of New Mexico), and the occasional teaching of various classes and labs.

Because the nurse-midwifery education program in the College of Nursing has been unable to fill a third faculty position, a creative arrangement between the CNM service and the College of Nursing will allow the CNM education coordinator to be "loaned" to the College for 30 hours per week in the first half of 1993. This individual will work on practice site development and student recruitment, coordinate one course, and supervise some advanced students in the intrapartum area.

THE COLLEGE OF NURSING

In the summer of 1990, FNS brought its final-year basic certificate program to the UNM campus. During that year, FNS faculty worked with the UNM College of Nursing to explore development of a master's-level nurse-midwifery education program at UNM that would be integrated with existing M.S.N. programs in the College. Funding from the Division of Nursing and approvals from state government and UNM were received in 1991, and the first class was admitted in January 1992.

In the spring of 1992, a preceptor development workshop was jointly organized by the College and the Nurse-Midwifery Division. Certified nurse-midwives from the UNM service and four other New Mexico CNM services participated. The ongoing communication and sharing that began at this workshop has facilitated clinical placements for student nurse-midwives around the state.

The support of the various CNM services in New Mexico, particularly the one at UH, has enabled the education program to become fully operational. The critical roles of the CNM Division Chief and education coordinator and their respective contributions have been discussed above. College of Nursing faculty have contributed to our joint mission in various ways: provision of some clinical services (usually with students, but at times without), presentations at the bimonthly CNM staff meetings on topics such as interpreting clinical research and evaluation of practice protocols, and assisting CNM staff with research and writing projects.

GRAVIDATA

Since July 1991, data on all women receiving care by the Nurse-Midwifery Division have been recorded on the Nurse-Midwifery Clinical Data Set (NMCDS) instrument (1). Beginning in October 1992, as a beta-testing site, we converted to the more efficient version, GRAVIDATA 2.0, a computerized version of the NMCDS. Previously, data were entered into earlier GRAVIDATA programs, versions 1.0 and 1.3. To date, information from 1,000 clients has been entered into GRAVIDATA.

The GRAVIDATA coordinator su-

TABLE 1
GRAVIDATA Short Statistics Form (January 1992 to June 1992)

	Client Caseload (n = 455)	
	n	%
Socioeconomic factor		
Race		
White	211	46.0
Native American	116	25.5
Hispanic	106	23.3
Black	17	4.0
Asian	7	1.5
Other	1	0.2
Payment source		
Champus	176	38.7
Medicaid	151	32.2
Indian Health Service	67	14.7
Private insurance	43	9.5
Self-pay	17	3.7
Variables		
Infant feeding method		
Breast	291	64.0
Bottle	109	24.0
Combination	14	3.0
Episiotomy rate		
None	332	73.0
Midline	92	20.2
Laceration rate		
Minor, no repairs	65	14.3
1°	47	10.3
2°	77	17.0
3°	18	4.0
4°	4	0.9
Membrane status		
SROM	250	55.0
AROM	182	40.0
Postpartum complications		
PPH	30	6.6

SROM, spontaneous rupture of membranes; AROM, artificial rupture of membranes; PPH, postpartum hemorrhage.

TABLE 2
On-Site Files for Research Process

Instructions
- Manuscript/journal(s)
- Department of OB-GYN Research Review Committee

Applications
- Human Research Review Committee
- Office of Research Administration—funding on-line data base
- Medline/Latch
- (NIH) Clinical Research Center

References
- Nurse-Midwifery Division Research Library
- Computer software (EPI Info, Word Perfect 5.1, Harvard Graphics 3.0, Lotus 3.0, GRAVIDATA 2.0)

these projects, three manuscripts have been submitted and another is in preparation. Additional efforts at sharing our work included presentations at the 1993 International Confederation of Midwives and the American College of Nurse-Midwives Convention.

SUMMARY

The Nurse-Midwifery Division, with the full support of the Department of Obstetrics and Gynecology, and with committed partners in the College of Nursing, is proceeding forward with a three-part mission: nurse-midwifery practice, teaching, and research. Our practice sites are likely to remain varied but stable, with half of our clients being either Hispanic or Native American. Our commitment to nurse-midwifery education is solid, and our participation in the process will continue to take several forms, including the central one of clinical preceptorships. Our research agenda will grow. We hope our experience with GRAVIDATA will contribute to the development of a national nurse-midwifery data base. Other future goals of our research program include collaboration in multisite clinical research projects, obtaining substantial external funding and recruiting doctorally prepared investigators.

Two individuals have been instrumental in bringing this article to fruition. Gloria E. Sarto, MD, PhD, is the Chair of the UNM Department of Obstetrics and Gynecology. She has firmly and consistently supported the Nurse-Midwifery Division in all aspects of its growth and development. Lisa L. Paine, CNM, DrPH, FAAN, Associate Professor and Director of the Nurse-Midwifery Education Program at the Boston University School of Public Health, has graciously served as a consultant and advisor to our service.

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Brief Report

Collaborative and Bidirectional Feedback Between Students and Clinical Preceptors: Promoting Effective Communication Skills on Health Care Teams

CEU

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Current literature on feedback suggests that clinical preceptors lead feedback conversations that are primarily unidirectional, from preceptor to student. While this approach may promote clinical competency, it does not actively develop students' competency in facilitating feedback discussions and providing feedback across power differentials (ie, from student to preceptor). This latter competency warrants particular attention given its fundamental role in effective health care team communication and its related influence on patient safety. Reframing the feedback process as collaborative and bidirectional, where both preceptors and students provide and receive feedback, maximizes opportunities for role modeling and skills practice in the context of a supportive relationship, thereby enhancing team preparedness. We describe an initiative to introduce these fundamental skills of collaborative, bidirectional feedback in the nurse-midwifery education program at the University of California, San Francisco.

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Keywords: collaboration, communication, education, empathy, feedback, health care team, hierarchy, patient safety, preceptor

INTRODUCTION

In 2015, the American College of Nurse-Midwives; the American College of Obstetricians and Gynecologists; the Association of Women's Health, Obstetric, and Neonatal Nurses; and the Society for Maternal-Fetal Medicine jointly issued a blueprint for transforming communication and safety culture in intrapartum care.[1] One explicit recommendation was to establish a team and organizational climate where skillfully "speaking up" is the norm and the development of communication skills, including feedback, is prioritized. Though not explicitly mentioned, clinical educators and education programs are well poised to answer this call. We propose that attention to the structure and process of feedback within student-preceptor relationships promotes this fundamental team communication skill. We also describe a practical intervention implemented by the University of California, San Francisco (UCSF) nurse-midwifery education program.

EFFECTIVE FEEDBACK PROCESS

Feedback is specific, nonjudgmental information, comparing performance with a standard, with an intention to improve performance.[2] Students and faculty alike must incorporate feedback to develop expertise in clinical and educational work.[3] A growing body of literature in health sciences education informs the provision of effective feedback to adult learners. In particular, goal setting, specificity, and increased frequency of feedback enhance its effectiveness.[4] Of additional importance is the inclusion of learner self-assessment, which promotes accountability, application of feedback, and the capacity for self-assessment.[5,6] In the clinical setting, a preceptor giving effective feedback: 1) asks the learner to initiate the session by identifying goals, 2) asks the learner to self-assess their skills, and, finally, 3) names observations and specific behaviors related to the goals.[4–6]

Receptivity and trust strongly influence the effectiveness of feedback between students and faculty. Medical students generally do not elicit feedback from clinical supervisors unless specifically coached; when they do, they prefer to ask faculty perceived to be more approachable than expert.[7] A qualitative study of midwifery students, medical trainees, and practicing physicians found that feedback recipients responded more positively when they believed feedback providers to be motivated by goodwill.[8] This finding should not be confused with an endorsement of praise ("good job!"), which preceptors often use in an effort to increase student satisfaction. Specific feedback that is reinforcing, corrective, and/or given in the context of a trusting relationship is associated with attainment of educational goals.[8–10]

For preceptors and students functioning within time-limited relationships and busy clinical environments, effective feedback must not undermine the ability to fulfill other responsibilities. An effective feedback process will therefore incorporate the core elements of goal setting, self-assessment, and specificity while also enabling rapid establishment of a trusting relationship. According to the Ask-Respond-Tell feedback model (Table 1), preceptors invite students' self-assessment, respond with reflective listening and empathy, and tell their perspective.[11] This conversational approach differs from the more common "download" and helps to establish partnership.[12] While other models also incorporate a dialogic approach and acknowledge the importance of student perspective, Ask-Respond-Tell additionally emphasizes the explicit expression of empathy, which is known to build relationships and, specifically, trust.[6,13]

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differently next time. My perspective is ..." In both cycles, feedback is preceded by a reflective and empathic response to the self-assessment. This emphasis on empathy fosters alliance building, as the student both experiences empathy and develops skill in its expression, with potential benefit for team function.[21,22]

An added benefit of this bidirectional approach is to inform preceptor development in real time, when feedback is actionable and results can be more readily appreciated than those generated through anonymous, delayed written feedback.[23] Understanding the student's assessment of the educational alliance enables the preceptor to build the alliance further, with potential to enhance the effect of future feedback encounters.[12] Role modeling continues as the preceptor demonstrates timely and effective incorporation of feedback into her or his teaching. By inviting feedback and receiving it gracefully, preceptors role model vulnerability across power differentials as a professional skill, with potential application to interprofessional team relationships. For example, a meaningful parallel can be drawn between a preceptor's elicitation of feedback from a student and that student's elicitation of feedback from a nurse about communication during an obstetric emergency.

ADDRESSING BARRIERS TO IMPLEMENTATION BY STUDENTS AND PRECEPTORS

It is important to recognize that both students and preceptors will have varied degrees of comfort with a collaborative and bidirectional approach to feedback. Preceptors may have experienced a different model as learners themselves or work in a clinical environment where feedback behaviors range from dysfunctional to threatening. Well-documented evidence of disconnection, unresponsiveness, and resignation among interprofessional teams in the intrapartum setting necessitates thoughtful consideration of this barrier.[18] Mentorship, perhaps among peers, may be especially important for these preceptors.

Students may be reluctant to assume an active role in the feedback process, especially in the provision of constructive feedback across a power differential. Thus, they may need repeated and explicit invitations by their preceptors to participate in these ways. An example might be: "When I was a student, I remember struggling with how to give feedback to one of my preceptors. I wish I had said something like, 'I find it difficult to tell you that I don't know something. It might help if you checked in about my confidence level before we discuss my management plan.' What similar things would you like to say to me?" Preceptors' self-assessment is especially important in these relationships as it offers an opening, and perhaps specific language, for the student to emulate. Students' and preceptors' open communication about the feedback process informs mutual goal setting and, ultimately, shared development of competency in providing and receiving feedback.

Implementing and maintaining this collaborative and bidirectional feedback model is undoubtedly complicated by the varied demands of a clinical learning environment, including time restrictions and limited opportunities for student-preceptor continuity. As with any novel skill, establishing a shared understanding and comfort with the feedback process may be time intensive at the outset, with increasing efficiency through repetition. In settings where learners work with multiple preceptors, especially preceptors who are dispersed in the community and potentially less familiar with the feedback culture of the education program, students may be well positioned to act as feedback ambassadors. In addition to representing their learning goals, they can also augment program efforts to orient preceptors to the process. Milan[7] described a successful intervention to promote feedback seeking on the part of third-year medical students. Following a 90-minute interactive feedback workshop, which addressed learners' demonstrated receptivity to, as well as solicitation of, feedback, student participants reported more feedback-seeking behavior than control subjects. These findings suggest that even a brief intervention has the potential to activate students. However, given students' lower position in the hierarchy, they cannot reasonably be expected to assume the role of primary change agent in an inhospitable feedback culture.

PROGRAMMATIC DEVELOPMENT

Because the implementation of a more collaborative and bidirectional approach to feedback likely represents a significant cultural change, it requires programmatic and structural support in addition to individual skill development. Henderson[24] described a yearlong medical education curriculum to develop individual feedback skills as well as to promote a work culture where bidirectional feedback across hierarchy is a norm. The model emphasizes skills practice between peers and in small groups, with both student self-assessments and faculty summative assessments documenting students' skills in providing and receiving feedback. This demonstrated value of peer and supervisor group learning environments can be applied directly to the development of feedback skills within clinical learning relationships. Instead of learning feedback skills separately, students and preceptors can be supported to develop this highly relational skill in a group that is integrated across the supervisory hierarchy. Students and preceptors can then be oriented to the process in ways that embody the key principles of collaboration and reciprocity.

We initiated, and herein describe, a clinically focused application at our institution. The UCSF nurse-midwifery education program was founded in 1977 and graduates approximately 15 nurse-midwives each year. The primary clinical site is Zuckerberg San Francisco General Hospital and Trauma Center, staffed by a group of 11 core midwifery clinical faculty, many of whom are graduates of the UCSF program, with between 10 and 32 years of professional experience. Prior to 2014, programmatic support for the feedback process mainly included separate workshops for students and faculty as well as case-specific mentorship of both students and faculty in challenging feedback relationships. Summative, written program evaluations by students suggested that while many students found relationships with clinical faculty to be supportive and feedback to be effective, some students were dissatisfied with what they perceived to be nonspecific or judgmental feedback and also struggled with communicating their concerns directly to clinical faculty.

In the fall of 2014, UCSF midwifery clinical faculty and students piloted a new approach to feedback skill

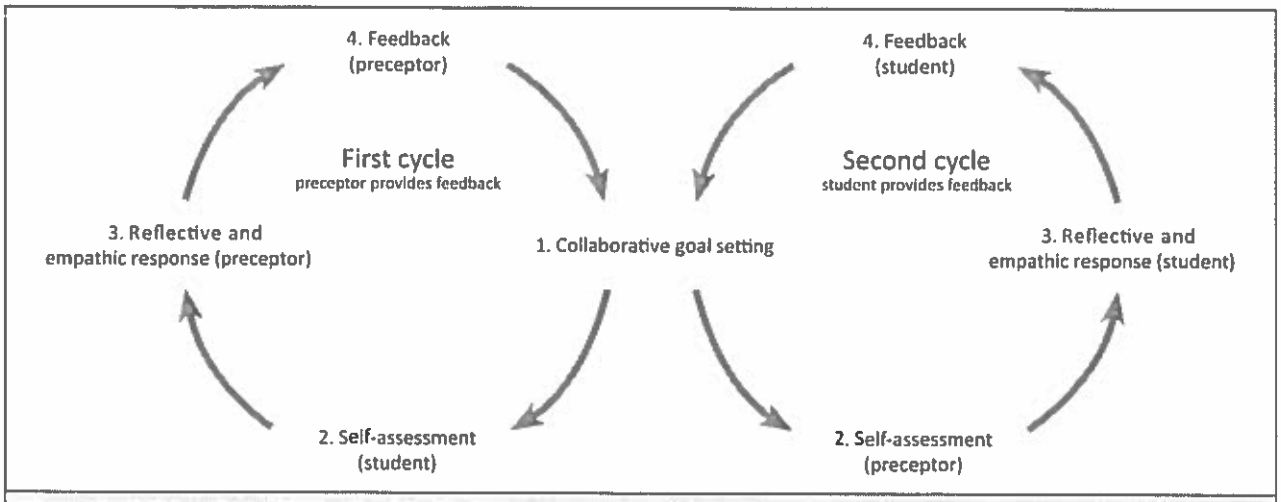

Figure 1. Collaborative and Bidirectional Feedback Process

The collaborative and bidirectional feedback process includes 2 cycles of feedback. In the first cycle, the preceptor is the feedback provider, and the student is the feedback recipient. In the second cycle, the roles are reversed. Collaborative goal setting (1) initiates both cycles, which then proceed through the following steps: (2) self-assessment, composed of reinforcing and constructive elements; (3) reflective listening and empathic response; and (4) feedback, again composed of reinforcing and constructive elements. Both cycles inform ongoing collaborative goal setting (restarting at 1) for subsequent clinical encounters.

development with an integrated, half-day workshop. The workshop included large group didactics and demonstrations but was primarily focused on facilitated small group skills practice, specifically role play, as an evidence-based educational tool for communication skill development.[25] In 4 groups of 6 to 8 students and preceptor faculty, distributed approximately half and half between groups, facilitators trained through the American Academy on Communication in Healthcare guided participants through role plays of common feedback scenarios, using cases generated by the participants themselves. Participants practiced each step of the model (Figure 1), including the provision of both reinforcing and constructive bidirectional feedback. Debriefing allowed for additional skills practice by including participants' self-assessments as well as feedback from peers and other group members. These public feedback opportunities supplemented the simulated exercises with real-time encounters, promoting self-awareness through recognition of one's impact on and response to fellow group members.[24]

At the conclusion of the workshop, participants completed a written, anonymous evaluation. Both faculty and students emphasized the value of the integrated learning environment, specifically the opportunity to practice feedback skills together. In setting intentions for change, the students used language representing themselves as active facilitators of the feedback process. For example, one student indicated that she would "be more confident in asking for the feedback [I] need, especially in asking [my] preceptor to self-assess and give [me] an opportunity to give her feedback as well." As a means of systematically reinforcing the facilitated skills practice, daily clinical evaluation forms were modified to be consistent with the model and include an elaborated prompt for faculty self-assessment and detailed feedback for faculty by students. Students identify aspects of the student-preceptor interaction that facilitate and hinder their goal attainment and also suggest means of enhancing the interaction. Preceptors specify which teaching strategies they would like to "keep, stop, and start" (See Supporting Information, Appendix S1).

The UCSF nurse-midwifery education program's efforts to design an effective feedback skills curriculum are ongoing. Successful transformation of communication and safety culture calls for a longitudinal approach.[1,24] Integrating ongoing, group-based learning opportunities has proven difficult in the context of busy curricula and clinical services. Efforts to identify opportunities for facilitated skills practice include contemplation of refresher sessions, which will focus on role play and debriefing. Based on student and preceptor feedback, the timing of the initial workshop has been modified to allow for earlier skill development in the course of the 2-year midwifery program. This adjustment also allows more time for reinforcement, both formally and informally.

CONCLUSION

Clinical preceptors have traditionally been represented as stewards of the feedback process and, in some cases, the assumption of this role is appropriate. However, it is unnecessarily limiting to uniformly appoint preceptors as primary facilitators of all feedback encounters or to routinely engage in unidirectional feedback. As students prepare to be effective communicators on interprofessional teams, they require opportunities to practice related skills, including feedback, in the context of supportive relationships. Students' feedback competency can be promoted through both programmatic efforts and individual skill development. Future research efforts should examine specific training and maintenance interventions for preceptors and students, as well as the effects of these interventions on measured competency in feedback. These efforts should integrate with the related and broader research endeavor of identifying practices that support effective feedback behaviors on interprofessional teams.[9] In summary, we advocate strongly for reframing the