30th August 2011

My name is Carolyn Ive and I have practised as a Maternal and Child Health Nurse in Victoria for 12 years. I am working in an acknowledged, high risk area, in the city of Frankston. (determined by the CFC - Community for Children). I am writing in response to the productivity Commission Early Childhood Development Workforce Report (2011). I am specifically responding to Chapter 12, particularly 12.3.

My qualifications include:
Registered Nurse since 1986 (Royal Melbourne Hospital- Certificate of Nursing)
Registered Midwife in 1989(Mercy Hospital for Women- Certificate of Midwifery)
Bachelor of Educational Studies (4th year post grad level)- Monash University- Melbourne- 1997
Post Grad diploma in Child, Family and Community Health- Latrobe University- Melbourne- 1999
Grad Certificate in Business Management- APESMA/ Latrobe- 2007
IBCLC- 1995-2005

My Midwifery, Registered Nursing and Maternal and Child Health Nursing are pre-requisites to the job of Maternal and Child Health Nursing (MCHN) in Victoria and provide me critical knowledge and invaluable professional skills to practice as a MCHN.

Chapter 12-

The context of this chapter has child health sitting on its own. In Victoria, we work with the family in context with the child and the community. Our required qualifications in Victoria support the ability to work with all aspects of the family to support the optimum outcome for the child. This is also reflected in the high percentage of families (95%) that attend our service. Where are those statistics even close to in the other states of Australia. Removing of Midwifery qualifications as recommended in 12.2 and 12.3 of the draft would reduce the quality of the Victorian MCH nursing service. We are called Maternal and Child Health Nurses for a reason. Not just child health nurse as reflected in the report. Our role with maternal health is just as strong as it is with child health.

As a midwife, I can and constantly do give

- Breastfeeding advice
- Ante-natal advice
- Post-natal Advice
- Debriefing of labour experience
- Labour options advice

The role of midwifery in MCHN has even been become more important with the early discharge from public hospital over the last decade. Mother's are coming out of the hospital with minimal knowledge and advice due to time constraints. I am usually visiting mothers between days 4 to day 8 post delivery, as they have been discharged from the hospital by this stage and hospital domicillary care has ceased. Many are discharged from hospital within 24 hours and with only one home visit from the hospital. Many women have not even established adequate breastmilk supply at this stage. The time I spend at the home visit is mainly divided between feeding the baby- predominantly time with breastfeeding and then assessing mother's physical and psychological health together with sourcing their supports and giving advice. Time is spent on debriefing the birth. Then there is the education aspect and alerting the family to signs and symptoms of complications such as intrauterine infection, blocked ducts and mastitis. Most of this visit is midwifery based and could not be done accurately and safely without being a midwife. Many times the knowledge of signs and symptoms of mastitis, intrauterine infection, vasospasm of nipples, in-coordinated suck pattern of baby, engorged breasts, incorrect breastfeeding attachment and jaundice are used. Many times I have had to refer mother's to GP's for complicating conditions. Referral back into hospital for jaundice twice in the last year has resulted in the baby's going under phototherapy. I have just received a call today (30/8/2011) re a mother's wound LUSCS opening up and was able to reassure her and give her advice. She is coming in to the centre with her 2 week baby today and I will be able to make a clinical assessment of the wound and refer if required. Without experience and knowledge of midwifery I would be unable to give that sort of holistic care.

The requirement to be a Midwife and a Registered nurse has not been a barrier at any stage to be a MCHN. In fact, without these qualifications together with my tertiary MCHN qualifications I would not have been able to practice in such a professional and thorough manner. Last year I auscultated two children with heart murmurs. Both were missed in hospital, both required surgery. Another child came to me at 2 years of age with an undiagnosed metopic craniosynotosis, that I detected and was referred on and also required surgery. I have undertaken countless lactation consultations within my practice to support mothers with breastfeeding issues. With the known benefits of breastfeeding to the child and the mother this is a very important role. I have referred many mothers for treatment for anxiety and depression. Once again knowledge and expertise I have gained through my training in becoming a Registered Nurse, Midwifery and MCHN has been paramount in the care I provide.

I strongly believe you need the full package of Registered Nurse, Midwifery and Maternal and Child Health Nursing to practice professional, safely and too provide high quality care. The high rate of usage by families in this state, I believe, is reflected by the strength of our profession by holding those qualifications. Not a fragmented service as in other states. Families come to our service knowing they have highly knowledgeable professionals, attending to their families

A practice nurse is not accredited or standardised. Their qualifications can be either as an enrolled nurse or a registered nurse. Some have very limited scope of practice regarding providing midwifery, care of young families and their mothers due to limited educational preparation. Their advice could be just based on their own experiences. Poor advice can lead to litigation. Our service provides these controls. We are mandated to keep our skills up to

date and to attend educational hours as part of our registration. We are required to be well qualified. We are required to document accurately.

The report makes an assertion without any supporting evidence, regarding outcomes. It states that " *the commission was not told of, nor could find, any evidence to suggest that Victorian Children have better outcomes than their counterparts in other states as a result of being seen by more qualified child health nurses'* . Assertions without evidence, is not an adequate evaluation of the service.

I find it hard to believe that limited consultation with MCHN in Victoria and very little recognition in the report re the very high participation with families in the Victorian system has occurred. Our service is superior. Families using the service report a very high level of satisfaction with the service. Where else in the country is there such high participation rates in child health services? I have families come from interstate and state that they cannot believe how much better our service is. Even families from overseas can not believe such a valuable service exists and how well it would work in their own country. This is a unique opportunity to capitalise and use as the Victorian MCHN services a basis to strengthen services in the other states. I would be grateful if the Commission would come together with myself and other colleagues to help the Commission understand our unique service.

I thank the Commission for considering my comments above.

I hope that the far reaching strengths of Victorian MCHN service can be a cornerstone for improving the services throughout the rest of the states of Australia and that recommendations are not imposed on this service that would erode and diminish the high quality of care that we provide.

Regards
Carolyn Ive MCHN, RM, RN, Grad Dip in Child, Family and Community, Ba. of Ed. Studies, Grad Dip. Bus. MGM.