Completing a maternal acute illness management course as part of the pre-registration programme

Student midwife Victoria Williams reflects on her experience of a course featuring simulation and role play, and how she will use the learning from this activity to improve her practice.

This article is a reflection based on completing the Maternal Acute Illness Management (M-AIM) course, and aims to explore the care provided during acute illness scenarios, focusing on communication and thought process (*Box 1*).

Description

The M-AIM course is a unique opportunity that the University of Salford offers to final-year student midwives, which is undertaken in the state-of-the-art simulation suite. Successful completion of the course is appealing to prospective employers, and it is invaluable for students' personal learning and development. The course was initiated in response to the 2011 Confidential Enquiry into Maternal Deaths report (Cantwell et al, 2011), where human error was a contributing factor to maternal death within the UK. The 1-day course is 'designed to educate and simulate AIM skills and increase confidence and clinical ability in early recognition, management and referral of the acutely ill woman' (McCarthy et al, 2014: 747). The aims of the course are outlined in *Box 2*. At the end of the course, I was inspired to undertake this reflection (which was not a requirement for my studies) because of the unique learning opportunity facilitated by knowledgable leaders.

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Feelings

Before participating in the course, I felt apprehensive because I was aware that role play would be a significant feature of the day. Simulation-based activities are deemed supportive for students' learning (Cant and Cooper, 2017; Yuill, 2017). However, the thought of simulation made me feel self-conscious and anxious. Previously, I have avoided playing an active role during simulation because I do not respond well to being put on the spot; I find it difficult to arrange my thoughts into a logical, methodical order. My cohort was split into two groups, to complete the 7.5-hour M-AIM course on separate days. Twenty-two people were registered to complete my course, and after a short lecture on the background of M-AIM we were split into smaller groups of five or six. Tiberius (2009) states that small groups are often more comfortable for learners, owing to our earlier life experiences of being around fewer people such as family and friends. I agree with this, as I felt comfortable embarking on the simulation task with four other student midwives and known midwifery lecturers in comparison to the larger groups I had previously experienced. Although I was not confident to volunteer for the first active role, I watched in amazement as my colleague completed the simulation based on an internal bleeding scenario. After she had finished the task, I offered her positive feedback to highlight how well she had dealt with the scenario, because supporting colleagues can boost morale and improve job satisfaction (Warmelink et al, 2015). I was able to complete the practice simulation successfully. The environment was supportive, and on a few occasions where I did lose my focus or make minor mistakes, I was encouraged and prompted by my colleagues. Following the practice simulation, I was able to complete the summative assessment with the assessor. I felt proud of my achievements at the end of the course, and reflected on how much I had improved since previous events including simulation, viva examinations and problem-based learning.

Box 1. Writing this reflection

To assist in writing this reflection, I have used Gibbs' (1988) reflective model, because the structure of this framework is precise and allows for an insight into different perspectives of the situation. This will help identify any amendments that may be made to my future practice, and support me in striving for continuous professional competence (Mann et al, 2009). Reflecting on practice and learning from experience is a continuous feature of personal and professional development. It has become evident that reflection is a key concept in bringing theoretical and practice learning together within the health and social care vocations (Clark, 2009).

To protect the identity of lecturers, clinicians and student midwives, no names have been used, in accordance with The Data Protection Act 1998 and the Nursing and Midwifery (NMC, 2015) *Code*.

Box 2. Aims of the course
To optimise the outcomes for women at risk of developing acute illness
To enhance the knowledge, confidence and performance of ward staff dealing with acutely ill women
To encourage teamwork and communication
To promote a multidisciplinary approach to care
To maximise the efficient use of critical care services
To address clinical governance and risk

Evaluation

Although midwives are defined as experts in normal pregnancy and birth, the fast-changing demographics of the UK and the advances in both medicine and technology have contributed to a rise in pregnancies that are no longer considered 'normal' (Edwards and Conduit, 2011; International Confederation of Midwives, 2011). Midwives are required to recognise when care falls outside of their scope of practice and take appropriate action (NMC, 2012). Cowley et al (2016) describe the use of methodical and robust tools as valuable during the assessment of acutely unwell patients to identify abnormal parameters. The M-AIM course provides midwives with methodical tools when encountering an unknown obstetric emergency, to stay within the midwife's scope of practice while prioritising the woman's safety (NMC, 2015).

Analysis

According to the NMC (2009), midwifery students are expected to meet the set standards and competencies in order to qualify as a midwife. However, in reality, newly qualified midwives report a lack of confidence in their ability to practise independently (Avis et al, 2013). The use of simulation provides students with an opportunity to practise real-life scenarios in a safe environment, consolidating knowledge and developing decision-making and problem-solving skills (McCarthy et al, 2014).

The M-AIM course began with a short lecture on the rationale, aims and objectives behind the course. This was beneficial because an element of theory prepared the students for what was expected in the practical simulation. In my past experience, I have lacked confidence in real-life simulation because I feel unable to verbalise my thoughts in a logical order. However, the M-AIM course focuses largely on the 'ABCDE' approach, entwined with a 'Look, listen, feel' technique. The ABCDE method stands for:

- Airway
- Breathing
- Circulation
- Disability
- Exposure.

Thinking in this order allowed me to process and make sense of the information, and make decisions based on my findings.

Towards the end of the scenario we were required to provide an accurate handover using the 'situation, background, assessment, recommendation' (SBAR) tool. This tool was first established in the military (Pope et al, 2008). I found it useful because each letter prompted me to relay the relevant information in a systematic order. I feel that by using this in practice I will improve my relationships with the multidisciplinary team, and improve women's safety by ensuring that all important details are handed over (NMC, 2015). Owing to the small number of people in the group and the new approach I had learnt, I felt confident to volunteer to act out a role play. I feel that this environment promoted empowerment because the students provided one another with moral support and valuable feedback. The research of Hunter and Warren (2014) reinforces this statement, with midwives viewing some working relationships as mutually supportive. The environment has also enhanced my clinical skills as a result of the simulated learning.

Honey and Mumford (1982) suggested that learning takes place in four different styles: activist, theorist, pragmatist and reflector. I believe that this experience has included all of these types of learning. Activists learn by doing, which is demonstrated by participating in the real-time role play. For example, I was required to apply the oxygen mask as I would do in practice. Theorist learning was applied during the lectures and weaved throughout the simulation. Learning the theory prior to the simulation helped to close the theory–practice gap which is often evident in health care (Tucker and Lowe, 2014). Pragmatist learning was included through the use of real-life scenarios. I was able to try different ideas and techniques that could also be applied to clinical practice. Prior to and on completing the M-AIM course, we were required to complete a multiple-choice questionnaire to assess our level of learning. This gave us the opportunity to reflect on what we had learnt. I am pleased to say I achieved 100% on the completion of the post-learning questionnaire, therefore I have evidenced that this type of learning was beneficial.

Conclusion and action plan

Gibbs' reflective cycle has supported me in making sense of the situation, and helped to put things into perspective. I have recognised that through the use of simulation my learning, development and confidence has grown, and I will apply this learning to my future clinical practice. I have recognised that although acute illness can be severe, my role as a midwife is firstly to call for help and then to manage the situation on a woman-centred basis, remaining within my scope of practice, until help arrives.

As a student midwife, I am continuously striving to enhance my skills and improve my professional development. I will use elements of this experience to aid my learning and develop my clinical practice. I aim to revisit the M-AIM material through a book that I have purchased. If an acutely ill women was to present at clinical practice, I hope that I can use the knowledge and skills that I have to request help, undertake an immediate

assessment, begin any treatments (within my professional boundaries) and, ultimately, save lives. BJM

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