School of Nursing and Midwifery

BACHELOR OF MIDWIFERY

(Graduate Entry)

CONTINUITY OF CARE PORTFOLIO

Student Name: _____

Student Number: _____

Students are required to submit this record at the end of their clinical placement each semester.

UniSQ

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Continuity of Care Experiences Portfolio

Introduction

According to the Australian College of Midwives, the Continuity of Care Experience is defined as “the ongoing midwifery relationship between the student and the woman from the initial contact in early pregnancy through to the weeks immediately after the woman has given birth, across the interface between community and hospital settings”. The aim of the COCE is to enable students to experience continuity with individual women through, pregnancy, labour and birth and the postnatal period and is an essential component of component of the BMID program. An appropriately qualified and experienced midwife must supervise students participating in this program.

The COCE record book allows students to compile evidence about their experiences and achievements when working in partnership with women who volunteer to participate in COCE program. It assists students to record evidence of achievement in meeting NMBA midwife standards for practice. Compiling information within this record and elsewhere serves as a data collection activity for USQ’s assessment requirements and registration purposes with the Australian Health Practitioners Regulation Agency (AHPRA).

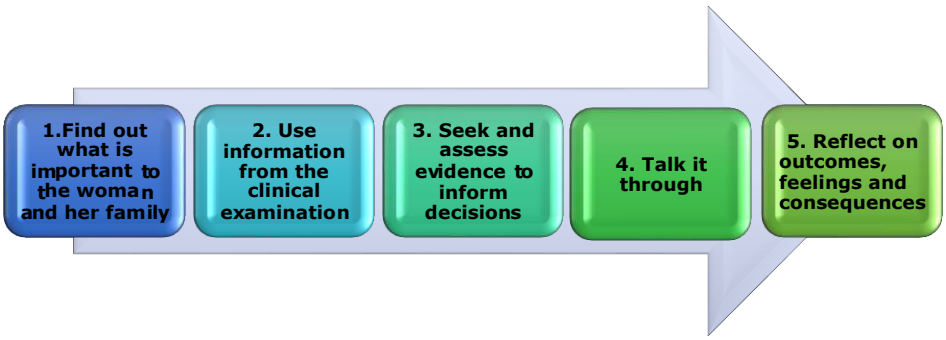
Recording information

The COCE record book contains templates for you record to your midwifery partnership experience with women as they experience pregnancy, birth, and the early days of parenthood. **You are required to complete and fill in all the spaces provided in the record templates.** You must ensure that a midwife, or other health care professional, signs each episode of care.

Reflection on practice

Reflection on practice is a key component of promoting best practice standards and care experiences for woman. Students are required to reflect on their COCE experiences and use to use a professional framework for reflection. The five steps of evidence-based midwifery practice developed by Lesley Page (2006), guide students learning when engaging in COCE journeys. Students are expected to read and understand the 5 steps of EBMP and use them to guide documentation of their COCE and reflection on practice.

(Source adapted from Page, L. & Percival, P. (2000). *The New Midwifery: Science and Sensitivity in Practice*. London, Churchill Livingstone, pp 9 -10.)



1. **Find out what is important to the woman and her family.**
   - Understanding the values, hopes and dreams of the woman expecting the baby.
   - How does the woman feel how about being pregnant?
   - What is important to you about your care/the birth of your baby?
   - Where would you like your baby to be born?

2. **Use information from the clinical examination.**

History taking:

- Is the woman generally healthy and well nourished?
- Is the woman a smoker?
- Is there habitual use of drugs or heavy alcohol consumption?
- Is there any history of illness that may be relevant?
- Is the woman well supported?
- Is she generally confident and how does she feel about pregnancy and birth?
- Are there any previous obstetric problems?

Clinical examination:

- Is the woman generally healthy?
- Are the woman's blood pressure and urine tests for protein within normal limits?
- Are there any cardiac or pulmonary anomalies?
- Are there any signs of disease or abnormal conditions?
- Is the baby healthy?
- Is the baby growing within normal parameters for its gestational age?
- Is there consistent fetal growth as measured by symphysis fundal (SFH) measurement or ultrasound scans?
- Is the baby active and moving?
- Is the fetal heart rate normal and reactive to stimulation?

3. **Seek and assess evidence to inform decisions.**

The clinical evidence a midwife or student of midwifery will need to seek out will vary and depend on what is important for the woman. Preceptors need to guide student's regarding the appropriateness of evidence.
Students note: should the woman ask advice, counselling or assistance, the student should refer her to the appropriate practitioner.

4. **Talk it through.**

Speaking with a woman about the evidence and what is important to her. Women need information, and some will want more information than others. It is important to provide women with the opportunity to discuss things that are important to them.

5. **Reflect on outcomes, feelings, and consequences.**

Reflecting upon one's own practice is important in this step. In addition, providing opportunities for women to discuss feelings, the outcomes and the consequences of decisions made, provides vital closure of a relationship.

The *initial* focus for the midwifery student is to:

- Develop a professional midwifery partnership relationship with COCE women and their family.
- Take an observational role of women and their families during the COCE.
- Develop an awareness for the needs of childbearing women and their families.
- Develop knowledge about the availability and accessibility of community resources available to women and their families.
- Develop understandings about midwifery-led continuity models of maternity care.

The *progressive* focus for the midwifery student is to:

- Maintain a professional partnership relationship with COCE women and their families.
- Undertake midwifery assessments with women throughout their journey of pregnancy, birth, and postnatal period.
- Provide care for and with the women and their family during pregnancy, birth, and postnatal period in a variety of settings under the supervision of a midwife.
- Evaluate any care provided and experienced by women, their families and by the student during the woman's pregnancy, birth, and postnatal period.
- Participate in, and evaluate, continuity of care models of maternity care.

Student's Responsibilities

- Prepare for the COCE experience by reading all instructions and Page's five steps to evidence based midwifery and *The Australian College of Midwives (ACM) Consultation and Referral Guidelines 3rd edition,*
- Recruit for the COCE. This may be done at a variety of venues and when on midwifery practice experience.
- Develop and maintain a professional relationship with the woman and her family.
- Work to your scope of practice as a student of midwifery and in accordance with NMBA Midwife Standards for Practice and professional codes (AHPRA, 2018).
- The nature of your professional role must be declared to the woman and her family.
- Gain informed consent from women prior to commencing the ongoing engagement.
- Provide each woman information about the COCE, the letter to the participant, and consent form provided in this book.
- Ask each woman to read the letter, answer any her questions regarding the COCE program.
- **The completed consent form and information letter must be uploaded to the appropriate submission point in InPlace within ONE WEEK of the recruitment**.
- Place a copy of the consent form in the woman's case notes at the midwifery practice experience facility and give the woman a copy as well.
- Always maintain care and confidentiality of the woman's private details.
- Record in your COCE record book a concisely (black ink) account of each woman's experience including time you spent with each woman on verification of visits record and timesheet. Record that this time occurred when attending a COC experience.
- Complete the specified number of COCE's for each clinical course.
- Critically reflect and record your partnership experiences with the woman.
- Develop an evaluation process so women can provide feedback regarding their level of satisfaction with your care and partnership experience from their perspective.
- Provide women with a reply-paid envelope to return her evaluation of the experience to the Midwifery Program Coordinator. (Suggest give this to the woman at the end of the experience)
- Ensure de-identification of the woman by giving her a unique code and record this on the evaluation forms to ensure anonymity.
- Take an observational and supportive role under the direct supervision of a registered midwife or other APHRA registered health professional.
- **Submit the completed COCE to the appropriate submission point in InPlace within two (2) months of DOB**.

Confidentiality

In accordance with the "Information Privacy Act 2009 (QLD)", when personal information as defined by the ACT is collected directly by USQ, USQ is required to disclose to that person, the reasons for collecting their personal information. They must also identify any third party to whom it may usually be disclosed to and details of any legislation under which the collection is made.

The collection notice is on the Continuity of Care consent form. Students have legal and professional obligations around collecting and handling women's personal information. It is important that you maintain the privacy and safety of any records that contain personal information of another person for example women's medical or obstetric history. Finally, students must not take photos of women, their babies or family or post images of women or intimate body parts on any social medial medium (Please refer to AHPRA Social Media regulation standard).

Consent process

- Provide women the information letter which can be found in this record book.
- Give women time to read and discuss the concept of participating in the COCE.
- Provide an alternative to receiving continuity of care information – literature or the Course Coordinator.
- If the woman indicates her willingness to participate, facilitate consent by providing her the consent form and ask her to sign and date it (see UniSQ COCE consent form at the back of this record book).
- Ensure consent form is completed appropriately.
- Provide a copy of the woman's consent to:
    1. The woman,
    2. The appropriate submission link in InPlace,
    3. The woman's hospital file.

Essential to the continuity of care experience, recruitment and subsequent follow through into the postnatal period, the careful planning and integration of the experience into your life, work, and study. This activity must be woman centred. That is, for the experience to be meaningful, the woman is placed at the centre of planning. The woman's needs are pivotal for planning and decision making for episodes of contact and care. It is essential to draw on the theoretical principles of partnership in negotiating episodes of contact with a woman. Evidence of this must be present in your documentation of the COCE.

Attending Continuity of Care Experiences (COCEs)

Continuity of care experiences are one group of experiences that students undertake within their allocated clinical hours for a given course. The total number of clinical hours for a clinical course is normally 310 hours, averaging to 40 shifts for most courses. This equates to a 0.5 FTE commitment during the year. If a student is following a woman's pregnancy journey for the purposes of gaining "Continuity of Care Experience" (COCE), this experience should occur during timeframes when the student is attending his/her allocated booked shifts at his/her clinical placement/host hospital site.
Attending clinical placement outside of these times is discouraged to avoid becoming over tired and stressed.

The COCE experience is not a substitute for attending hospital care experiences- i.e. attending clinical shifts at a service site. Therefore, students cannot substitute large volumes of hours e.g. 100, 200, or more by only attending COCEs. Students are required to gain balanced exposure to maternity care service provisions to ensure the full range of care experiences are gained.

Attending clinical placement outside of rostered shifts

For the purposes of workplace health and safety and insurance liability, students are encouraged to avoid attending unbooked clinical placement hours outside of booked or rostered shifts/hours. However, if it does become necessary to do this, aim to keep these types of visits to a minimum.

Due to the nature of the COC experience and the professional relationship that midwives form with women, it is acknowledged that there may be times when a student may choose to attend their host hospital during his/her "off duty" time to be with COC woman. Examples of times that are permitted and reasonable to attend a COCE woman outside of a rostered shift are as follows:

- The woman attends the hospital for an additional unscheduled assessment and calls the student.
- Scheduled antenatal appointments at the host hospital or off site at a related service site for example a GP appointment or MGP clinic.
- Childbirth classes.
- The woman goes into labour and is having her baby.
- Students may simply not have been able to attend a scheduled antenatal appointment due to other commitments or may choose to attend more than the required x 4 antenatal visits to gain a more comprehensive experience.

Students must not pressure or coerce women to schedule their care around the student's needs. The student is a guest who is following the women as and when able.

In all of these scenarios, the student should have organised these unscheduled visits with the woman and the supervising midwife/health practitioner. Meetings with the woman should occur during the course of scheduled care experiences (check-ups, pathology, radiology, education) therefore; the student is accompanying the woman as she sees registered health professionals. Students should not be seeing women for social catch-ups. If it becomes necessary for the student to attend a woman's appointment outside of the student's booked clinical placement shift, the time spent providing direct care can be *'counted'* to the overall clinical placement hours.

Examples of scenarios when students may count time spent with a COCE woman outside of booked hours/shift.

> *The student is working a paid shift in another area of the hospital and is called to her COCE women to provide care and hopefully assist the women to birth her baby*.

In this scenario, it is the students responsibly to negotiate with her manager to be released to attend her COCE women. Only the time spent providing direct care under the supervision of the midwife can be "counted' and contributing to the overall 155hours for clinical placement.

> *The student is completing a clinical placement shift on a post-natal floor and her COCE woman comes in for an antenatal appointment, unscheduled antenatal assessment, or care during labour.*

In this scenario, the student should negotiate with his/her preceptor for the shift to be excused from the allocated area. The student then attends their COCE woman. The time spent providing direct patient care to the COCE woman in this type of scenario is part of the normal shift time and does not need any adjustments.

> *The student has worked a full shift and birth is imminent for her COC woman. The student wishes to stay with the woman to support her and "catch" the birth.*

In this scenario, the student needs to be mindful of Workplace Health and Safety regulations to ensure she takes the recommended breaks. Please refer to the USQ Professional Practice Placement Handbook for more information on the WHS policy.

Applications for extension of time to complete COCEs

If a student has not completed the requirements of the COCE by the end of the clinical course, they should:

- Communicate with their 'Course Examiner" for the given course to discuss the circumstances.
- Submit an 'Extension for time application" to the course examiner specifying on the application form they are applying for both:
    - Additional clinical placement hours
    - Extension of time for submission of assessment items related to that course.

The course examiner upon receipt of this application will communicate with the clinical office to check if additional time (and thus insurance cover) can be organised with the service site where the student is attending clinical placement. Due to the nature of how clinical placement is managed by individual service sites, there is no guarantee this can be arranged. The student must not attend COCEs outside of booked clinical placement hours unless an extension of time has been approved. Only COCE associated with course requirements can be considered for extensions of time.

Students need to be enrolled in a clinical course to commence clinical placement and to attend appointments with COCE women.

Examples of scenarios when student should not be counting time for clinical placement hours:

- Time spent travelling to and from the hospital to attend COCE women.
- Time spent waiting for appointments.
- Phone calls, texting or emailing COC women.
- Social encounters – accidental meeting at the supermarket.

Students need to be either observing or providing direct clinical care under the supervision of a midwife or registered health professional for time spent with a COC woman to be counted.

All time spent with a COC woman needs to be documented and signed for by the supervising midwife or registered health professional who is responsible for the women on the 'Verification of Visits' form (p16). Visits that are not signed for will not be counted.

Episodes of COCE partnerships

Course	Number of COCE	Learning objectives
MID1199 Midwifery Practice 1	2	Establish a relationship with 2 (two) woman and continue the care through the woman's pregnancy, birth, and early weeks of pregnancy. Document this care contemporaneously in the template provided, complete a student evaluation once care has ceased.
MID1299 Midwifery Practice 2	2	Establish a relationship with 2 (two) woman and continue the care through the woman's pregnancy, birth, and early weeks of pregnancy. Document this care contemporaneously in the template provided, complete a student evaluation once care has ceased
MID2599 Midwifery Practice 3	3	Establish a relationship with 3 (three) woman and continue the care through the woman's pregnancy, birth, and early weeks of pregnancy. Document this care contemporaneously in the template provided, complete a student evaluation once care has ceased
MID2699 Midwifery Practice 4	3	Establish a relationship with 3 (three) woman and continue the care through the woman's pregnancy, birth, and early weeks of pregnancy. Document this care contemporaneously in the template provided, complete a student evaluation once care has ceased
Total	**10**	

Students may complete their COC experiences at different times, and this is dependent upon recruitment and flexibility when on placement.
All students must complete four (4) COCEs in their first half of study and six (6) in their second half of study.

Continuity of Care Experiences Requirements

Students are required to provide evidence of having engaged in the provision of care during your partnership and engagement with COCE women. This will require students to not only document clinical observations but also critical reasoning and the student's action having complete midwifery assessments. In accordance with ANMAC standards students are required to follow a minimum of 10 women and for the *'majority'* to be present for the labour and the birth.

The COC experience for 10 women must incorporate the following ANMAC requirements for each woman:
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- A *minimum* of four antenatal visits; - meaning there may, and preferably will, be more.
- The labour and birth.
- A *minimum* of two postnatal care visits, one in the early postnatal period and another at some stage up to 6 weeks postpartum

Submitting the COCE completed record for assessment.

Students are to record their COCE using the templates provided in this record book and use Pages Five Steps to Evidence based midwifery practice to discuss the woman's experience and care provided. How to use Pages Five Steps to Evidence Based Practice will be studied in semester 1 of the program. Once the student has fully completed a COCE record, a copy of the complete record must be uploaded to the student's electronic portfolio. A complete record includes the following:

- A copy of the information letter provided to the woman with her name written on the letter.
- A copy of the signed consent form, inclusive of the unique id code and signed by a midwifery educator/ facilitator.
- A full, complete, and comprehensively documented record of the experiences that occurred throughout the COCE journey. This should demonstrate good evidence of "Pages Five Steps" to demonstrate Evidence Based Midwifery practice has been used effectively.
- A copy of the students' evaluation of the experience
- All documents associated with each COCE experience must have the Unique ID code for that woman recorded.

Confidentiality

No hospital stickers are to be placed on COCE records kept by the student, as this constitutes a breach of patient confidentiality. Breaches of patient confidentiality may result in disciplinary action and could result in a student experiencing:

- Disciplinary action.
- Removal from placement.
- A 'fail' grade being recorded for a clinical course.
- Student needing to repeat the course.

Information Letter and Consent Document to participate in Continuity of Care Experience (COCE)

Academic Affairs, School of Nursing and Midwifery
D Gleeson Program Director, Bachelor of Midwifery
P: (07) 4631 5346
E: danielle.gleeson@unisq.edu.au

Dear

My name is Danielle Gleeson, I am the Program Director of the Bachelor of Midwifery (BMID) Program at the University of Southern Queensland (UniSQ). UniSQ Midwifery students, as trainees, are required to practice developing a professional partnership with a number of women experiencing pregnancy, childbirth and early parenting.

This letter forms part of a Midwifery student's introduction where they may ask you to participate in their learning and COCE partnership. If you consent with being involved in the Program, it will comprise of the student meeting with you a minimum of four (4) times during your pregnancy, being present for your labour and birth, and meet a minimum of two (2) times in the early days following the birth, and up to six weeks after the birth of your baby.

The Student will, at all times, provide care under the *direct* supervision of a registered midwife. You will continue to receive the normal care provided by the qualified midwives and/or your doctor. Midwifery students are not able to provide direct midwifery care without supervision. If you have questions about your health, pregnancy, birth or the time after the birth or your baby's needs, our students may attempt to answer them under supervision or refer them to your registered midwife or doctor, but in any event, you should still consult directly with your doctor and/or midwife.

There may be a time where the student may not be present for your baby's birth even though you both plan for this outcome.

If you choose to participate in the Program, it will be appreciated if you would assist in the following way:

- Discuss with the Midwifery Student a schedule of contact that is most convenient for you.
- Allow the Midwifery Student to give me your name and telephone number in case I or another staff member of the university needs to contact you.
- Complete and sign the consent form. This form confirms your participation in the Program, and your agreement to assist the Student in acquiring experience. A copy of the consent will go in the Student's Midwifery Practice Portfolio (MPP), which is a UniSQ document (available to the Student), and one will be provided to your hospital for their records.
- At the end of your COCE partnership with the Midwifery Student, complete and return to me at UniSQ an evaluation form that will be provided to you by the Student once you agree to proceed with the partnership. A copy of this form will be included in the Student's MPP and be available to the Student. The purpose of the evaluation is to assist the Midwifery Student to learn from the experience and for UniSQ to assess the Student and generally improve the learning experience for students.

Please note you are free to withdraw from the partnership or Program at any time. To withdraw, you simply need to advise myself that you no longer wish to participate. To contact me, please use the details above. There will be no negative consequences for you by withdrawing.

If you proceed, UniSQ thanks you most sincerely for being a part of the learning experience for the student and we hope that you enjoy the experience.

Kind regards,

Danielle Gleeson
Program Director, Bachelor of Midwifery

Danielle Gleeson
Bachelor of Midwifery
Program Director
P: (07) 4631 5346
E: Danielle.gleeson@unisq.edu.au

Consent Form for participation in Continuity of Care Experience

I,_____(full name) consent to participate in the Continuity of Care Experience as part of the Bachelor of Midwifery Program by having Midwifery Student _____ (midwifery student's name) meet with me to provide care, throughout my pregnancy, (minimum of four (4) antenatal visits, labour and birth (if possible) and minimum of two (2) postnatal visits up to 6 weeks). This will occur under the supervision of a midwife or other health care professional. I understand that copies of this form will be held by UniSQ (accessible by the Midwifery Student named below) and be provided to my hospital for inclusion in my personal hospital record. I understand that the Midwifery Student has a responsibility to provide advice or care only in the presence of a registered health professional. Any questions I have about my health, the pregnancy, the birth, postnatal period, my baby and infant feeding cannot be addressed by the Midwifery Student unless in the presence of a registered health professional and I consent to the Student referring questions to a midwife or other health care professional.

I understand that I can withdraw at any time as set out in the Information Letter for the Program.

Midwifery Student's name:	Woman's name:
	Estimated DOB:
Signature: Date: / /	Signature: Date: / /
Mobile phone number:	Mobile phone number:
Unique Code:	
Signed: Facilitator/Educator	Date……..

University of Southern Queensland (UniSQ) is collecting personal information on this form for university purposes of providing its tertiary education and related ancillary services and the associated functions. Your personal information will not be disclosed by USQ to any other third party, other than as set in the information letter for the Program without your consent unless required or authorised to do so by law.
Your rights to access and amend your personal information are set out in the Information Privacy Act 2009 (Qld), which also places obligations on USQ as to how it handles your personal information. For further information concerning Privacy, please direct any queries to the USQ Privacy Officer (privacy@unisq.edu.au) or go to www.unisq.edu.au/aboutsite/privacy

Please note: Records and information are held and dealt with by UniSQ in accordance with the Public Records Act 2002 (Qld), Right to Information Act 2009 (Qld) and Information Privacy Act 2009 (Qld)

	Woman's Unique ID				
Woman's Evaluation of Continuity of Care Experience					

Midwifery student to complete this initial section at the beginning of the partnership, then provide this form and a UniSQ reply paid envelope to the participant.

Student name:_____Student no:_____

Woman to complete this section at the completion of the midwife-woman partnership:

Thank you for participating in the continuity of care relationship with your USQ Midwifery Student. We value your feedback. It will help us to improve the way we prepare our students to work in partnership with women.

Would you please respond to each of the statements below by circling one of five numbers?

Strongly disagree	Disagree	Not Sure	Agree	Strongly agree
1	2	3	4	5

If you are unsure or cannot comment on a particular statement, please leave that statement blank. Please provide any comments you have about the student or the experience at the end of this document.

Questions	1	2	3	4	5
1. The midwifery student provided me with a clear explanation of what to expect in the continuity of care experience (COCE) partnership.					
2. The midwifery student always kept planned appointments or meeting times.					
3. The midwifery student always gave me plenty of notice if plans had to change.					
4. The midwifery student respected my ideas and did not judge me.					
5. The midwifery student provided safe and competent midwifery care under the supervision of a midwife.					
6. The midwifery student assisted me to feel supported both emotionally and physically throughout our COCE partnership.					
7. The midwifery student encouraged me to make my own decision.					
8. The midwifery student always made it clear that choices were mine to make.					
9. The midwifery student encouraged me to trust childbirth as a normal event.					
10. The midwifery student provided permitted information when I needed it and encouraged me to discuss what I wanted.					
11. The midwifery student, with my consent relayed any concerns to a registered midwife and/or doctor to promote my clear understanding of care provision and potential outcomes.					
12. The midwifery student communicated effectively with my support people and me.					

List 3 things you like about having a midwifery student.

1. ……
2. ……
3. ……

List 3 things you did not like about having a midwifery student.

1. ……
2. ……
3. ……

I would recommend the Continuity of Care Experience partnership with a midwifery student to other women.

Yes **No**

Additional comments

……

……

……

Thank you for your time in filling in this evaluation questionnaire. UniSQ appreciates your feedback.

University of Southern Queensland (UniSQ) is collecting personal information on this form for university purposes of providing its tertiary education and related ancillary services and the associated functions. Your personal information will not be disclosed by UniSQ to any other third party, other than as set in the information letter for the Program without your consent unless required or authorised to do so by law.

Your rights to access and amend your personal information are set out in the Information Privacy Act 2009 (Qld), which also places obligations on UniSQ as to how it handles your personal information. For further information concerning Privacy, please go to www.unisq.edu.au/aboutsite/privacy or direct any queries to the UniSQ Privacy Officer (privacy@unisq.edu.au).

Verification of COCE Visits

Use this form to record the health care professional signatures as verification of your COCE visits.
Please use one form for each COCE woman record.

COCE Unique Id:		Student Name	Student Signature
Date and Time of Visit	**Type of Visit**	**HCP Name**	**HCP Signature**

Student Evaluation of Continuity of Care Experience

The experience of providing continuity of care is a mandatory requirement for student midwives to complete during their training to become a midwife and is designed to support preparation for practice as a registered midwife. Students are required to provide feedback about the COCE experience in terms of how the experience and your participation in Continuity of Care contributed to your learning to become a midwife.
Please indicate your response in the options provided below.

Key: Strongly Agree (S/A), Agree (A), Strongly Disagree (S/D), Disagree (D), Not Applicable (N/A)

The Continuity of Care experiences allowed me to:	**SA**	**A**	**D**	**SD**	**NA**
1. develop and exhibit a midwifery philosophy that is respectful, dignified and woman-centred when working in partnership with childrearing women and their families within human rights and educational frameworks;					
2. Demonstrate critical thinking skills aligned with core values of midwifery practice and collaborate effectively with partners considering historical, social and political influences;					
3. Contextualise legal and ethical frameworks to demonstrate professional midwifery practice reflective of cultural awareness and the individuals rights to social justice;					
4. Analyse and evaluate models of care, leadership and entrepreneurship to meet the needs of mothers and babies in contemporary society;					
5. Provide safe, competent and woman-centred care for women, babies and families across the continuum of pregnancy, childbirth and transition to parenting within diverse cultural, ethnic and socioeconomic populations;					
6. Integrate evidence based practice to inform clinical decisions and foster change in relation to maternity services and maternity care;					
7. Apply knowledge and skills to demonstrate autonomy, well-developed judgment and responsibility in the context of increasing clinical competence and safety in the delivery of professional midwifery practice;					
8. Enable graduates to be eligible for registration and care of women as accountable, autonomous professionals.					

List three things learnt through this experience that you will bring with you into your future practice:
……

……

……

……..

Student Signature:

Date:

Guideline on how to document the Continuity of Care Experience

Student Name:			**Student Number:**		
COCE Code:	**Maternal Age**	**Parity**	**EDD**	**Gestation**	**BMI**

Obstetric/Psychological history:

May record in dot point format to briefly provide a comprehensive obstetric history and list any known risk factors

Continuity of Care Experiences with woman		**NBMA Midwife Standards**
Date/s	**Initial Interview Details** Using your initial interview details, write a brief 'snap shot' account of the COCE woman and tell her story in a brief narrative.	Document the relevant midwife standards for practice care links to.
	Record of Ongoing Partnership Development Record a reflective journal of the partnership by using a dot point format for each meeting. Document the ongoing partnership development in a professionally appropriate manner (not "met for coffee") Record all minimum visits in detail, including the birth experience - even if minimum visits not achieved in relation to special approval if one experience missed. Aim to provide comprehensive documentation of pregnancy journey.	Document the relevant midwife standards for practice care links to. All visits to be signed for on 'Verification of Visits form" including time spent.

Page's 5 Steps Evidence Based Midwifery

6. **What is important to the woman?**
   Identify one issue or topic that is important to your COCE woman (different issue for each COCE woman), and examine the issue using Page's 5 steps as a framework

7. **What does the clinical examination reveal?**
   Reflect on the issued identified above, consider the clinical information in the woman's history and current situation

8. **What does the evidence say?**
   Reflect on the issues identified above, students are expected to find and examine the evidence/literature to explain what the student has learnt from this.
   (Document references used at the bottom of the page)

9. **Talking it through**
   In regard to the issues identified above, students are to consider the evidence, the woman's own feelings and views. Talking it through may mean an actual discussion with the woman, taking care not to provide advice without guidance from your mentor, or another midwife or doctor. You could talk it through here in this COCE record to develop your clinical reasoning. (Remember all care or advice you provide must be under the supervision of a registered midwife, you are not the caregiver responsible for the woman)

10. **Reflecting on outcomes**

In regards to the issues identified, consider what was important to the woman, what happened (outcome), how did the woman feel about what happened with her birth experience and outcome, how did you feel about this, what were the positive or negatives, was there anything that could have been done differently to improve this woman 'care experience, reflect on yourself, how did you fit in and experience this woman partnership experience	
Summary of Continuity of Care Partnership Reflect on this COC experience and consider • What have you learned and gained professionally? • What has the woman gained from this experience? • What skills and strengths have you developed? • Were there any challenges or areas you would like to develop further in your future practice?	
Total hours	**Mentors Signature (when COCE complete)** **Print Name……..Designation……..** **Midwife Signature……..... Date……**

References

Example of comprehensive documentation for COCE required.

Student Name: Jane Smith			Student Number: U0000000000		
COCE Code:	**Maternal Age**	**Parity**	**EDD**	**Gestation**	**BMI**
COCE1	18yrs	G1P0	10.05.18	20/42	26
Obstetric/Psychological history: Nil					

Continuity of Care Experiences with woman		**NBMA Midwife Standards**
Date	**Initial Interview Details**	
28.11.17	16^{+5} /40 weeks; BP85/50; FHHR 140bpm; Wt. 55kgs; BMI 26 At MMs first booking in appointment, she elected to attend a young parents group as her model of care. She attends with her young male partner, her baby's father. Has recently (6/52 ago) had a urinary tract infection, now clear. Has experienced some stress incontinence at times. MM is a non-smoker, her partners smokes. Family history of cardiovascular disease (father), sister had GDM, and toxaemia during her pregnancy, her mother has a history of post-natal depression. MMs scored 5 on EDS assessment. Taking vitamin D, no other medications. Thyroid blood tests (TSH1.6) HB 126, platelets 250. Blood group, A positive, is not immune for rubella, Negative for infectious diseases. MM is generally she is a well young woman. However, due to family history of gestational diabetes, an early test for gestational diabetes is planned. 6/52 prior she attended her sisters birth as a support person so has some knowledge of what to expect with birthing.	Midwifery standard 2: Engages in professional relationships and respectful partnerships. (2.1,2.2,2.3;2.4;2.5;2.6;2.7)
Date/s	**Record of Ongoing Partnership Development**	
06/02/18	26^{+5}/40; BP 100/60, Fundal Height 26cm; FHR 135 bpm; 0GTT booked for 12//02/18. Feeling well, nil pain with urination, nil discharge. Whooping cough immunisation discussed. Importance of fetal movements discussed. Also discussed a visit/meeting with the YPG social worker next visit. MM and her partner are living with her parents. First OGTT WNL (14.4;5.8;5.6) HB 114, platelets 263 MM has agreed that I may follow her childbirth journey as a student midwife and has signed the consent form.	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4)
20/02/18	28^{+5}/40; FHR120; Abdominal Palpation to assess growth and wellbeing: Foetus lying in long position, left occipital anterior position. Uterus measuring 30cm fundal height. BP 100/70; 2^{nd} OGTT and WNL (4.3, 5.0, 4.0), weight 63.2kgs. Discussed need for rubella vaccination following birth as MM not immune at present. Discussed birth plan and plans for placenta to be taken to New Zealand, as MMs cultural beliefs require burial of placenta on ancestral lands. Discussed plans on how to make	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4)

	arrangements with customs at birth. Recent ultrasound results: baby measuring slightly larger than 78%. MM mentioned her breasts have grown from a B cup to an F cup and has noticed the presence of colostrum since 20/40. MM has noticed increased pressure under her diaphragm making it hard to breathe. Advised how this is related to growth of baby and height of fundus. Says it's hard to take a deep breath. Advised to use firm supportive bra and to sit with her arms above her head at time as this can provide some relief for improved depth of inspiration. Discussed both pain and MMs thoughts for pain relief during labour. All assessments and discussions documented in PHR.	
06/03/18	31/40 weeks, BP 110/70.FHF 135-140 bpm; Weight 65.3kgs. Feeding well, nil concerns. Blood pathology form given to check Vitamin D levels ad this was low earlier in pregnancy. Also, Thyroid function	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4)
03/04/18	34 $^{+5}$/40; 64.4kgs; BP120/70; Fundal height 36.5cm; Foetal position ROA; FHHR 145-150; Blood results checked: MM's blood results show TSH 1.6-wnlT47.7; MM mentioned that she has been spotting blood which was about the size of a 10cent piece on the 20th March 1018. MM attended ANDAS at hospital and a speculum was performed: thrush noted. Also concerned as feeling dizzy lately and very tired. Pathology form completed to complete iron studies and repeat Vitamin D (Vitamin D levels low earlier in pregnancy) Discussed reasons for changes in blood volume hemo-dilution Which can cause these symptoms. Also discussed signs and symptoms related to pre-eclampsia – as her sister had pre-Eclampsia for 2 pregnancies. Visual disturbances, headaches, Epigastric pain, swelling in hands, feet, and face. Discussed post-natal depression signs with MM and her partner; and the need to get help (sister and brother both had both experienced this). Edinburgh depression scale assessment completed again as per guidelines an showed NAD. Antenatal breast milk expression discussed – MM had a lot of colostrum – advised re Breast care.	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4) Midwife standard 1: Promotes health and wellbeing through evidence based midwifery practice. (1.2;1.3, 1.5) Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4)

17/04/18	36 $^{+5}$/40; Weight 70kgs; BP 110/70; HB 103: Platelets 78. Iron Studies WNL: transferrin 4.8 (1.6-4.8). Transferrin saturation 4(1.4-4.5). Taking iron supplements in liquid form. Has had whooping cough vaccination. Expressing breast milk +++	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4)
20/04/18 16.30-18.30	37 $^{+1}$/40; MM telephoned birth suite during my rostered shift. She stated that she was concerned about reduced foetal movements. Birth suite midwife asked MM to come in for an assessment and monitoring. On arrival to birth suite @ 16.30; vital signs performed; CTG performed – good beat to beat variability (6-25 bpm), reactive- reassuring CTG as foetal movements ++. Urinalysis FHHR 140. CTG reviewed by Medical Officer – discarded at 18.30 with reassurance and encouraged to contact the hospital again if concerned.	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4) Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4)
08/05/18 03.15 hrs	39^{+2}/40. *TXT communication:* Presented to birth suite at 03.15 after texting me. MM reported she had been contracting from the previous day and her contractions were now becoming more painful. Contractions 3-4/10, moderate intensity, lasing 40-50 seconds. Nil PV loss. On arrival to birth suite, vaginal examination performed: Cephalic presentation, laying in the Left occiput position, foetal head was 3/5 palpable above the symphysis pubis (abdominal palpation); Cervix dilated 4cm, 0.5cm thick stretchy. Fore waters felt. – 2 station. CTG recording performed and accelerations noted after VE. Foetal heart rate 130bpm. MM does not request pain relief required at this time. Transferred to birth suite at 06.30 am.	Not in attendance as was unable to get to the birth suite until 17.00hrs. Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4) Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4)

08/05/18 08.00 hrs 11.45hrs	39+2/40 *TXT communication* Birth Suite: VE: 6cm dilated, cervix 0.5 cm effaced, foetal head station -1cm above ischial spines. As contraction frequency reduced, (2-3:10; lasting 50-70 seconds, moderate –strong). ARM performed with consent – clear liquor draining. CTG in progress, (FHR 125-130 bmp), >6 bpm variability, accelerations present, nil decelerations). MMs is mobilising around the room, using the shower for pain relief. Plan: Oxytocin if contractions do not increase in frequency, hence IV oxytocin on commenced 1ml/hr as per hospital protocol. Clear liquor draining, and to be reassess in 4 hours. IV oxytocin to be increased to 2mls/hr; 14.45 4mls//hr.	Not in attendance as unable to get to birth suite until 17.00 Telephone contact with BS only**.** Midwife standard for practice 2: Engages in professional relationships and respectful partnerships (2.1, 2.2,2.3 2.6, 2.7)
08/05/18 12.15rs 13.30hrs 15.15hrs 15.30hrs 16.05 hrs 17.00hrs 17.30hrs	MM is contracting 3:10 lasing 60-70 seconds in duration. Nitrous oxide in use with a 30/70 mix. Voiding regularly. CTG: some variable decelerations were noted lasting a short duration, and recovered quickly. Bloody show was noted, MM feeling increased pressure and urge to push. Oxytocin increased to 12ml/hr, then reduced to 8ml/hr due to contraction rate increases (5-6/10 minutes). Moderate to strong lasting 30-60 seconds duration. CTG: variable decelerations with contractions, FH 125-130 bpm. Using N^2 0^2 @ 50/50 concentration. MM feeling the urge to push. Fully dilated, commenced pushing. Contractions 4-5:10; strong lasting 30-60 seconds. My arrival to birth suite: I requested permission to enter the room and MM was happy to have me present. Oxytocin running at 8mls/hr. Contracting 4-5:10 and MM is pushing. Head on view with pushing. FHR 145bpm however, deceleration to 110 with contractions. MM using stirrups to push.	Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4) Midwife standard 3: Demonstrates the capability and accountability for midwifery practice (3.1, 3.2) Midwife standard for practice 2: Engages in professional relationships and respectful partnerships (2.1, 2.2,2.3 2.6, 2.7)

17.44hrs	Head born, difficulty delivering shoulders with usual traction. Anterior shoulder appeared to be impacted. Compound presentation: anterior hand across chest, unable to deliver. Emergency buzzer activated. MM placed in the McRoberts position @17.45. Suprapubic pressure applied @ 17.47 from maternal right hand side (unsuccessful). Posterior arm delivered	Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4)
18.20 hrs	17.47. IMI Oxytocin 10 units administered. Male infant born @ 17.48. Liquor clear throughout, meconium present at birth. Cord cut immediately by father and neonate transferred to resuscitation trolley. Neonatal NP in attendance. APGARs 7 @1 and 9 @ 5mins. Resuscitated using mask PEEP and IPPV briefly. Heart rate 129 bpm, respiratory rate 44bpm, $sp0^2$ @ 97%. Vitamin K given. Neonate transferred to special care nursery for assessment and observation. Father accompanied baby due to concern by midwife that baby appeared to exhibit decreased right shoulder movement after birth. X-ray NAD. Referred for physiotherapy assessment. Baby weight: 3590: 3590gms. Head circumference 43.5cm; length 52.5cm.	
18.30hrs	Attempted medical management of $3^{rd.}$ stage: delivery of placenta by CCT and uterine guarding. Placentae slow to separate. Fundus central and firm. Gravity used to assist with placenta delivery. MM stood at the side of the bed after 45 minutes– Nil effect. Requested assessment from registrar: despite using toilet to void. MM's bladder contained urine in/our catheter used. 100mls drained. Placenta was delivered after voiding. Placenta and membranes appeared complete. EBL estimated at 300mls. IVI oxytocin increased to 168mls/hr. Perineal examination revealed 1^{st} degree tear, bilateral grazes, not sutured as per registrar decision.	Midwife standard 3: Demonstrates the capability and accountability for midwifery practice (3.1, 3.2, 3.5, 3.7, 3.8)
18.30-21.00	Initial post-natal period: Post-partum observations of MM were satisfactory. No further blood loss. Fundus central, firm and contracted. Baby and dad returned to birth suite after x-ray at 19.00 hrs. Skin to skin and breastfeeding commenced. Good latch and feed. Transferred to ward after a shower at 21.00 hrs. Placenta taken home by family (consent form signed by MM and Father).	Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4) Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4. 2;4.3;4.4)

09/05/18	MM discharged at midday into care of supportive family. Rubella immunization administered prior to discharge. Family follow up appointments made for healthy hearing, home maternity services and physiotherapy review with instructions re how baby uses his right arm (all obvious weakness observed while in hospital).	Not in attendance
15/05/18	MM visits Young Parents antenatal support group. Baby boy 8 days old .MM reports she is enjoying parenthood as is her partner. Breastfeeding going well. Maori cultural practice is not to wash the baby until 5 days old. Her baby boy is very aware of his family and turns to all voices, healthy hearing has been performed and reported to be within normal limits. He does not appear to have any remaining issues with his right arm as a result of the shoulder dystocia manoeuvers. He has full movement. MM is taking the progesterone only pill for contraception and we discussed the importance of using alternative contraception if she misses dose. MM is also breastfeeding her sisters baby at present as her sister has been unwell. MM was advised about accessing the child health drop in clinic.	Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4) Midwife standard for practice 4: Undertakes comprehensive assessments (4.1;4.2;4.3;4.4) Midwife standard 5: Develops a plan for midwifery practice (5.1, 5.2, 5.3, 5.4) Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4)
Page's 5 Steps Evidence Based Midwifery		
	What is important to the woman? MM presents as an independent, calm young women who identifies as Maori. She and her supportive young male partner are very happy to be bringing their new baby girl into the world. MM's family is also very supportive and she is particularly close to her older sister, being present as a support person for her sister who birth a baby boy 2 months prior. There is a plan for MM and her family to move to New Zealand later in the year to live with extended family. The couple are very happy about this. MM is keen to have a natural labour and to breast feed her baby.	

	What does the clinical examination reveal? MM had been mostly healthy throughout her pregnancy. She is of small stature, and her BMI indicates she is within a healthy weight range (Diabetes Australia, 2018). Her pregnancy progressed well and within normal expected parameters and she demonstrated physical and psychological health through regular attendance at a Young Parents Group for her antenatal needs (Pairman, Tracey, Sally, and Dixon 2018). She entered labour naturally and laboured well with minimal pain relief as she had planned. Her labour was augmented with an Artificial Rupture of Membranes (ARM) and IV Oxytocin when her contractions frequency deceased. 'Shoulder dystocia" was an unexpected birth complication for MM. In hindsight, however, it was noted when MM was at 28/40 weeks gestation, that her baby was predicted to be in the 78 percentile for size and was told not to worry about it at the time!
	What does the evidence say? Menticoglou (2016) highlight is that recognition of shoulder dystocia should occur when neither shoulder births after two or three minutes, despite good maternal pushing efforts during the contraction following the emergence of the head. Thorogood (2015), also points out that a prolonged second stage, difficult birthing of the face or chin, a tightly applied head to the vulva (with or without retraction or 'turtling') and failure of the head to restitute, are all signed of a shoulder dystocia. In MM's case, she had a prolonged second stage of labour with a combined tightly applied head to the vulva despite maternal pushing effort. Shoulder dystocia can occur during a vaginal birth and may necessitate additional obstetric manoeuvres to be made to help birth the foetus after the head has birthed and gentle traction has failed. A shoulder dystocia can occur because of foetal anterior shoulder becoming impacted on either the maternal symphysis pubis or posterior foetal impaction on the sacral promontory (Royal College of Obstetricians and Gynaecologists (RCOG), 2012). The obstruction occur at the pelvic brim- the pelvic inlet, and so traction on the foetal head alone will not be effective in true shoulder dystocia (Thorogood, 2015). Additionally, head traction to try to relieve the obstruction can then be the cause a brachial plexus palsy, which occurs secondary to trauma to some or all of the brachial plexus nerve roots cranial nerves 5-8, thoracic nerve 1. This may be a temporary or permanent condition (Smith and Patel, 2016). The RCOG Greep Top guidelines (2012) estimate an incidence of shoulder dystocia between 0.58 & 0.7% but acknowledge a wide variation in reporting characteristics of a foetus or mother that might enable prediction of these complications have been sought. Mehta and Sokol, (2014) evaluated the literature to determine indicators and predictors of risk. They highlighted limited research on shoulder dystocia mainly by the retrospective nature of its definition. The most common factor in the occurrence of shoulder dystocia is foetal macrosomia with approximately half of all shoulder dystocia's occurring in large for gestational age infants, observing weight after birth. RCOG, (2012), highlights that foetal weight is not considered a good predictor of shoulder dystocia as intrauterine foetal size is difficult to determine accurately as ultrasound estimates are inaccurate at a rate of 10%. Additionally, a large majority of infants with a birth weight of ≥4500gms do not develop shoulder dystocia. Shoulder dystocia also occurred in 48% of cases where the infants weight is less than 4000gms as in MMs case. MM's baby was 3590gms at birth.

	Maternal diabetes mellitus, vacuum or forceps assisted births and previous shoulder dystocia are all also risk factors for shoulder dystocia. However, none of these histories was relevant for MM. Some research has suggested a relationship between labour dysfunction, (prolonged first or second stage) and shoulder dystocia, and particularly in nulliparous women (Mehat & Sokol , 2014). Mehta and Sokol concluded however, that the variability on findings made these risk factors unlikely as independent predictors. They suggested that they might be more predictive in combination when occurring simultaneously. That is, foetal macrosomia coupled with prolonged second stage of labour (>2 hours), and use of operative mid-pelvis vagina delivery techniques appear to increase the occurrence of shoulder dystocia and neonatal morbidity (2014). Overall, however, while predictive of risk factors have been suggested based on recorded incidence of shoulder dystocia, women have normal births despite the presence of one or more of these risk factors, while women without risk factors, and/or small for gestational age infants can also experience shoulder dystocia (RCOG, 2012). Illustrating that shoulder dystocia is not predictable. Additional elements may also affect the occurrence of shoulder dystocia according to midwife scholars. Birth by its very nature, occurs within a dynamic/evolving set of mechanical events (Thorogood, 2015, p1104). A woman's position if semi-recumbent has been implicated in causing an increased incidence of shoulder dystocia as this position reduces the diameter of the pelvis, compressing the sacrum on the bed. In contrast, standing, squatting in an all fours position or side lying positions are recommended (Reid, 2015 in Thorogood 2015, p1105). MM was semi recumbent in stirrups for her second stage of labour. Another factor that might have been relevant to MM was her height – 155cm. Thorogood, 2015) lists maternal short stature as a possible risk factor, and others (Mazouni et al. 2010) support this belief. Short stature is also cited as a predictor for shoulder dystocia in the guidelines, however high body mass index >30 is a risk (RCOG, 2012). MMs BMI was 20. I concluded that in MMs case, shoulder dystocia was not predictable. It was recognized and managed effectively. Firstly by unsuccessful use of the McRoberts manoeuver, then an unsuccessful attempt at suprapubic pressure. Movement of the anterior shoulder was next attempted but the foetus's arm was bent with a complex hand presentation. This made it difficult to move. Finally, rotation of the posterior shoulder and removal of the posterior arm proved to be successful. The baby was born 4 minutes after the birth of the head, which is within the recommended 5-minute interval beyond which hypoxic ischaemic encephalopathy risk increases (Leung, Stewart, Sahota Suen, Lau, Lao 2011). Following the birth, I debriefed with the midwife to establish a better understanding for why the McRoberts manoeuver did not work. She indicated that possible reasons for the failed McRoberts. Firstly, it appeared the supra pubic pressure had been applied from the wrong side of the woman and it appeared to be superior to the location of the shoulder. In performing the suprapubic pressure, the aim is to decrease the bisacromial diameter of the foetus within the pelvic by placing pressure on the posterior aspect of the anterior shoulder, keeping in mind the foetal position (Thorogood, 2015). It is clear, that for success of the McRoberts manoeuver, one must have knowledge for where the foetal spine is by abdominal palpation. A contrary view is held by Menticoglou (2016), who cautions that when these manoeuvers are made, they are often followed or accompanied by downward traction on the foetal head. This should be avoided or minimized to avoid brachial plexus injury through stretching (Smith & Patel , 2016). He cautions that while gentle downward traction is suggested in most guidelines (including RANZCOG), perhaps on some occasions this traction has been more than gentle,

	resulting in brachial plexus injury. He additionally cautions that anterior suprapubic pressure and Rubin's 11 manoeuver (attempting to internally rotate the anterior shoulder under the symphysis pubis) both may lead to inadvertent downward traction on the head and should be avoided. Menticoglou (2016) advocated removal of the posterior shoulder via the sacral space, after McRoberts had been performed omitting the anterior manoeuvers. MM's shoulder dystocia was relieved by removal of the posterior arm, and while the midwife thought, she had felt an injury occur, MM's baby was fine and MM did not experience any other complications such as post-partum haemorrhage. A known complication for shoulder dystocia (Thorogood (2015). Unfortunately, the Royal College of Obstetricians (2012) cite a recurrence rate of between 1-25% for women with one experience of shoulder dystocia. This was not discussed with MM at this time but should be considered if she became pregnant again. Midwifery standard 6: Provides safety and quality in midwifery practice (6.1, 6.2, 6.3, 6.4) Midwifery standards 7: Evaluates outcomes to improve midwifery practice (7.1, 7.2, 7.3)
	Talking it through MM and her partner are enjoying parenting immensely. MM is breastfeeding well and is also wet-nursing her sister's baby. MMs baby boy is thriving among this close knit, supportive family.
	Reflecting on outcomes Providing continuity of care for a young woman has been very rewarding. MM appeared to be an independent, self- assured young woman with good family support. Despite this, I was still able to provide her additional support via text messaging, ensuring her midwife answered her questions therefore, acted as a conduit between her and midwifery service providers. In developed countries, wet nursing is rare, though it is recommended by the World Health Organization (WHO) as preferable to artificial feeding if maternal breastfeeding is not possible (WHO), 2003). However, cross nursing or cross feeding, the informal practice of sharing breastfeeding among equals, such as sisters or friends, continues today and is often reciprocal. Further, there may some concerned about the theoretical risk of transmission of HIV or hepatitis C (Thornley, 2008). In this scenario, MMs cultural values and beliefs were respected and supported which was very rewarding to witness. I feel my involvement in this experience supported MM enormously emotionally and improved her access to quality care for her, her infant and family. This will have set her up for positive parenting experiences. MMs commitment to breastfeeding and her sisters baby was also very encouraging.
	Summary of Continuity of Care partnership Not only have I enjoyed the relationship and partnership I formed with this woman whilst providing continuity of care within a midwifery model of care, this experience and reflection has provided me the opportunity to investigate shoulder dystocia against the literature in great depth. I have found this very useful; making it much clearer in my head therefore, has helped prepare me for future occurrences.

	Mentors Signature (when COCE complete) **Name:** Helen Funk **Designation:** RM **Signature:** [signature] **Date:** 30·7·2018.

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Example of comprehensive COCE documentation, provided by UniSQ midwifery student Helen Gunter, graduated from the BMID (GE) in 2018