NURSING+ MIDWIFERY

The introduction of RUSOM staff at Western Health: Experiences of staff, supervisors, and women.

Professor Linda Sweet, Dr Vidanka Vasilevski, Ms Sue Sweeney

Western Health

DEAKIN UNIVERSITY

Executive Summary

The Registered Undergraduate Student of Midwifery (RUSOM) workforce model provides final year midwifery students an opportunity to obtain paid employment and gain experience as an assistant to registered midwives. A RUSOM supports the work of Registered Midwives by providing basic care to women and their newborns and associated administrative tasks. Each RUSOM is supervised by a Registered Midwife who is responsible and accountable for the tasks that are delegated to them.

Western Health was the first Victorian service to employ RUSOM. In November 2020 14 RUSOM staff were employed to support the postnatal care provided at Joan Kirner Women's and Children's (JKWC), Sunshine Hospital. These appointments were unique as they were the first to be established in Victoria. As limited research has been undertaken on the RUSOM role in Australia, it is important to understanding the experiences of staff and how the role contributes to the quality of care provided at Western Health. This report details the mixed methods evaluation undertaken of the outcomes of the first six months of operation with RUSOM on postnatal wards.

To gather a broad and representative understanding of the impact of the role, data was collected from the RUSOM, maternity care staff and women who received care from RUSOM. Additionally clinical audit data including Riskman entry numbers, MET call frequency and type, and length of stay were also reviewed.

The introduction of the RUSOM role has had numerous benefits for the service, midwifery staff and the RUSOM themselves. The RUSOM were able to relieve the burden on the postnatal ward, giving midwives more time to engage in direct clinical care. This was able to enhance the support given to women and improved their quality of care. Having a clear scope of practice for the role ensured there were clear boundaries between the RUSOM and the midwife, resulting in the positive satisfaction for the maternity services team. Employing RUSOM staff has the potential to improve the professional development of upcoming midwives, leading to high quality and experienced graduates that are an invaluable asset to a recruiting maternity service such as Western Health.

Key findings

- The RUSOM role was beneficial for the daily workflow in the health service.
- Women and midwives valued the care provided by the RUSOM.
- The RUSOM valued the ability to work autonomously, to build their clinical skills and professional identity.
- No RUSOM worked outside of their scope of practice and no incidences were reported during the evaluation period.
- There were no clinical incidences as a result of RUSOM care.

Key recommendations

- Review the task list of care RUSOM can provide
- Consider extending the hours RUSOM are employed
- Consider extending the locations in the health service in which the RUSOM can work
- Maintain the support for the RUSOM by allocating them a specific team and manager
- Supply dedicated DECT phone for RUSOM only to avoid the use of personal devices.

Contents

Executive Summary 1
Key findings 1
Key recommendations 1
List of Tables and Figures 3
Introduction 4
Method 5
Study Setting 5
Study Design 5
Results- Quantitative 6
RUSOM 6
Midwives 9
Women 11
Results- Qualitative 14
Theme 1: Getting everyone 'onboard' 14
Anticipations of the role 14
Getting started 15
Theme 2: Getting the 'hang' of the RUSOM role 16
Performing within scope of practice 16
Learning while working 18
Managing university and work expectations 19
Theme 3: Reciprocity of the role 20
Being with woman 20
Building confidence and identity 22
Data Audit 23
Exclusive breastfeeding on discharge 23
Riskman entries 23
MET calls 24
Length of stay 24
Discussion 25
Limitations 26
Conclusion 27
References 28
Appendix 1 29
RUSOM (Registered Undergraduate Student of Midwifery) Core Activity & Exclusion Lists 29

List of Tables and Figures

Table 1: Characteristics of RUSOM staff 6
Table 2: Experience of the RUSOM role 3 months post-implementation 7
Table 3: Other types of tasks completed 9
Table 4: Characteristics of midwife participants 9
Table 5: Women's experiences of care provided by RUSOM staff 12
Table 6: Riskman entries Jan - Jun 2020 and 2021 24
Table 7: MET call type and frequency 24
Table 8: Length of postnatal stay by ward 24
Table 9: Length of postnatal stay by ward and weekday versus weekend 25

Figure 1: Types and frequencies of tasks completed by RUSOM staff. 4
Figure 2: Midwife work satisfaction since introduction of RUSOM 10
Figure 3: Types of support women received from RUSOM staff 13
Figure 4: Themes and sub-themes 14
Figure 5: Exclusive breastfeeding rates on discharge 23

Introduction

The Registered Undergraduate Student of Nursing (RUSON) workforce model provides Bachelor of Nursing students an opportunity to obtain paid employment and gain experience during their second or third undergraduate years as a nurse assistant. The current Victorian enterprise agreement has a clear role for the RUSON, however, there has been no equivalent role for the Registered Undergraduate Student of Midwifery (RUSOM) in Victoria. A RUSOM supports the work of Registered Midwives by providing basic care to women and their newborns and associated administrative tasks. Each RUSOM is supervised by a Registered Midwife who is responsible and accountable for the tasks that are delegated to them.

These RUSOM/RUSON health assistant roles have been developed as a means to support the health care system and alleviate midwifery and nursing workforce shortages (1, 2). They also benefit the student as they promote development of clinical skills by immersion in the clinical environment and provide a means for financial support while studying (3). Direct exposure to the workforce also builds skills for work readiness upon graduation.

Although RUSON/RUSOM staff have been working in Australian hospitals for a number of years, there has been limited research exploring their experiences and the experiences of staff supporting them. There have been a few pilot projects and studies that have evaluated the RUSON role in the nursing setting (4-7), however only one study has been written on how the RUSOM are received in midwifery services (2).

Evidence from pilots in Victorian hospital settings suggested that RUSON/RUSOM were appreciated by staff (2) and patients, and the implementation of their roles were associated with reduced overtime and agency costs (4).Furthermore, they worked effectively within their scope of practice, promoted satisfaction of their colleagues, improved the quality of patient care (2), and their presence on wards were associated with reduced incidences of patient falls (5). The benefits and challenges of a RUSON role were outlined by Algoso et al. (6), finding that having such a role allowed RUSON staff to feel part of the hospital team, to have direct involvement in patient care, and to make a real impact with their work. They also reported a greater sense of autonomy, opportunities to develop critical thinking skills, and enhanced confidence and mastery in basic nursing skills. The RUSON staff reported that these opportunities were limited in traditional clinical placement experiences during their university degrees. The participants did however express some challenges of being a RUSON, such as the limited understanding of the role by nursing colleagues, and being asked to work outside of their scope of practice (6).

Similarly, other Australian studies, though not focussed on RUSON specifically, found that nursing assistants were involved in greater direct patient care (7), were well received by clinical teams, and were associated with a reduction of adverse events on wards (8). Roche et al. (7), however, also found that the level of direct care conducted by registered nurses increased with the presence nursing assistants, indicating a doubling up of work and reduced efficiency (7).

International studies of similar roles have found some consistent findings, such as increased quality of care and reduced adverse events associated with the introduction of nursing assistants in hospitals (9). In line with Australian RUSON staff, nursing assistants stated that such a role helped them to develop skills and increase confidence (10-12). However, challenges have also been noted in these studies such as high turnover of nursing assistants due to low job satisfaction (13), not being used to their full capabilities (14), being asked to conduct tasks outside of their scope of practice, role confusion (12) and limited emotional support for their roles (10).

Little research has examined the RUSOM role in Australia. One survey study set in Victoria found that a similar role improved graduate employment readiness, increased skill confidence and loyalty to the health service (2). Two studies from the United Kingdom have analysed the role of the midwifery assistant. Brown (15) found the registered midwives were concerned about erosion of the midwife role due to the introduction of midwifery assistants. They called for a better clarification of the midwifery assistant role and how it complements the role of the registered midwife. The need for role boundaries was echoed by Hasson (16), who also found that midwifery assistants completed both direct and indirect care to women, but more often completed indirect tasks such as providing assistance with comfort, mobility, hygiene, personal care, communication, and collection of specimens.

Western Health, for the first time, employed 14 RUSOM staff to support the postnatal care provided at Joan Kirner Women's and Children's Hospital (JKWCH) at Sunshine Hospital. These appointments were unique as were the first to be established in Victoria. As little research has been undertaken on this role in Australia, understanding the experiences of staff and how the role contributes to quality of care provided at Western Health was warranted.

The aims of this study were to:

- Explore the expectations, experiences, and satisfaction of the RUSOM role by RUSOM staff, registered midwives, midwifery unit managers, and medical staff.
- Understand women's experiences and level of satisfaction with care provided by RUSOM staff.
- Conduct an audit of data related to breastfeeding rates and Riskman incidences (log of adverse events and near misses) on maternity wards, comparing periods prior and post introduction of RUSOM roles.
- Conduct an audit of MET calls and length of stay comparing periods prior and post introduction of RUSOM roles.

Method

Study Setting

The study hospital is one of the largest maternity hospitals in Australia, now recording over 6500 births per year. The RUSOM staff were employed to assist in the maternity wards providing care for non-complex antenatal and postnatal women. There was a specific core activity list (see Appendix 1) that identified what the RUSOMs were allowed and not allowed to perform, and this was distributed across the wards. The RUSOM were employed on six hour shifts (8am to 2pm or 2pm to 8pm), Monday to Friday for this trial period. They were allocated to a specific ward and had a known unit manager and clinical midwife educator for support. All required leave for university was provided to not affect their studies. The RUSOM were not allocated specific women, but rather were a roving assistant able to provide care to any woman or assist any midwife throughout the shift. Potential tasks were noted on a white board in the staff station by the midwives or the RUSOM were contacted by a ward phone when required.

Study Design

A mixed-methods approach including qualitative focus groups and descriptive surveys was used. Ethics approval was obtained from the hospital ethics committee (QA2020.45.65484). Participation in the study was voluntary and consent was implied upon completion of the surveys or attendance at the focus groups.

Qualitative focus groups to examine initial expectations of the role were separately conducted with RUSOM and midwifery staff prior to or immediately upon commencement of the role in November and December 2020. A total of 26 people (14 RUSOM and 12 midwives) participated in five focus groups. At 6 months post implementation, qualitative focus groups were separately conducted with RUSOM and midwifery staff to explore overall experiences of the role and to identify potential areas for improvement. A total of 15 people (12 RUSOM and 3 midwifery managers) participated in four focus groups. Focus groups ran between 30 and 60 minutes and included up to eight participants in each. All focus groups were audio recorded, professionally transcribed, and checked for accuracy.

Descriptive surveys were designed to explore the experiences and work satisfaction of the RUSOM role. They were distributed to RUSOM staff, midwives on the maternity wards, and medical staff four months post implementation (April 2021). A total of 12 responses from RUSOM, 74 responses from midwives, and no responses from medical staff were received.

Women who were over 18 years of age and had received care from a RUSOM were invited to share their experiences and satisfaction of care provided by the RUSOM via an electronic descriptive survey which were distributed from 3 months post implementation. A total of 49 women responded to this survey. The online platform Qualtrics® was used for the online surveys.

Quantitative data from surveys were summarised as frequencies and percentages using Microsoft Excel. Qualitative data were combined and thematically analysed using the methods described by Clarke and Braun (17) and managed with NVivo® software.

Results- Quantitative

RUSOM

Characteristics of the sample

A total of 13 of RUSOM staff entered the survey, however, 12 completed all the questions. Characteristics of the RUSOM participants are shown in Table 1. All the RUSOM participants were female, and the majority were aged between 18 and 24 years. All the RUSOM participants were in their final year of their midwifery degree, with over half completing a 4-year degree and the remaining a 3-year degree. Advertisement of the RUSOM role was most identified through online advertising, university information, via friends or colleagues or directly through the Western Health website. All but one of the participants intended to apply for a graduate year at Western Health at the time of the survey.

Table 1: Characteristics of RUSOM staff

		n (%)
Gender	Female	12 (100.0)
Age	18 - 24	8 (66.7)
	25 - 34	3 (25.0)
	35 - 44	1 (8.3)
Midwifery undergraduate level	3rd year of a 3-year degree	5 (41.7)
	4th year of a 4-year degree	7 (58.3)
How did you find out about the RUSOM role?	Online advertisement	3 (25.0)
	University	3 (25.0)
	Friend or colleague	3 (25.0)
	Western Health website	3 (25.0)
Intend to apply for graduate year at Western Health?	Yes	11 (91.7)
	No	1 (8.3)

Experience of the RUSOM role four months post implementation

As shown in Table 2, all the participants agreed that the onboarding process and transition to the workplace was relatively smooth. Once undertaking the role, the RUSOM staff agreed they were appreciated and supported by the teams they were working with. All but one participant agreed they received adequate supervision while they worked on the postnatal ward. None of the participants agreed that they felt overwhelmed by the role, however, 7 participants indicated that they had been asked to complete tasks outside of their scope of practice and 2 had been asked to complete tasks that they had not yet been trained to do. Over 90% of RUSOM participants agreed that they had more skills than they could apply to their work within the RUSOM role. All the RUSOM participants strongly agreed that the work was enjoyable, and the majority indicated that it was stimulating. All but one of the participants agreed that they

would continue in the role if they were offered ongoing employment. Over 90% of RUSOM staff agreed that participating in the role added benefit to their midwifery education.

Table 2: Experience of the RUSOM role 3 months post-implementation

	Strongly agree n (%)	Somewhat agree n (%)	Somewhat disagree n (%)	Strongly disagree n (%)	Not applicable n (%)
The employment on-boarding process was smooth and efficient	7 (58.3)	5 (41.7)	0 (0.0)	0 (0.0)	0 (0.0)
I found the transition from my study to the workplace seamless	8 (66.7)	4 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)
I feel I am a valued member of the team	11 (91.7)	1 (8.3)	0 (0.0)	0 (0.0)	0 (0.0)
I feel supported in my role	8 (66.7)	4 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)
I receive adequate supervision	5 (41.7)	6 (50.0)	0 (0.0)	0 (0.0)	1 (8.3)
I feel out of depth in my role	0 (0.0)	0 (0.0)	1 (8.3)	11 (91.7)	0 (0.0)
I have been asked to conduct tasks that are outside of my job description	1 (8.3)	6 (50.0)	1 (8.3)	4 (33.3)	0 (0.0)
I feel I have more skills to offer than I am currently allowed to use	6 (50.0)	5 (41.7)	1 (8.3)	0 (0.0)	0 (0.0)
I have been asked to do tasks that I have not been trained to do	0 (0.0)	2 (16.7)	2 (16.7)	8 (66.7)	0 (0.0)
I find the work enjoyable	12 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
I find the work stimulating	8 (66.7)	4 (33.3)	0 (0.0)	0 (0.0)	0 (0.0)
If I was offered ongoing employment, I would continue in the role	10 (83.3)	1 (8.3)	0 (0.0)	0 (0.0)	1 (8.3)
I feel the RUSOM experience will be invaluable to my studies	10 (8.3)	1 (8.3)	0 (0.0)	1 (8.3)	0 (0.0)

Types of tasks completed by RUSOM staff

Tasks completed by RUSOM (Figure 1) that were indicated as being conducted 'always' included, providing baby bathing support (n=11, 92%), assisting women to feed their babies (n=9, 75%), talking to women (n=8, 67%), providing health education (n=7, 58%) and answering call bells (n=7, 58%). They often conducted bed linen changes (n=6, 50%) and baby settling (n=6, 50%). Many regularly assisted women to mobilise and communicated to the broader healthcare team. None of the participants reported that they conducted tasks outside of their scope of practice such as medication administration and vital signs assessment.

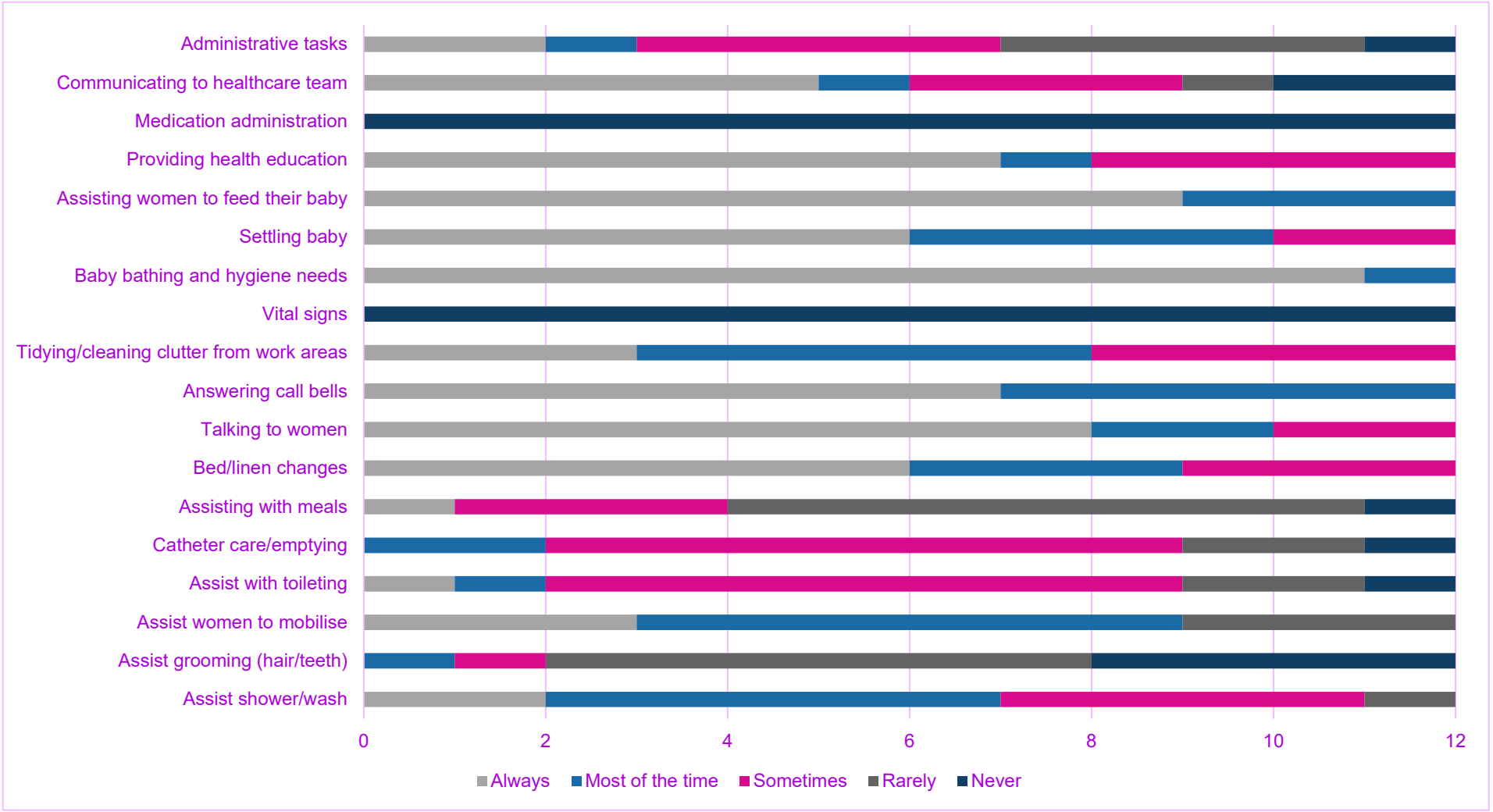

Figure 1: Types and frequencies of tasks completed by RUSOM staff.

Other types of tasks completed

RUSOM participants were asked to comment on other tasks they had conducted in their role as a RUSOM at the hospital (Table 3). Most reported activities included assisting women and their families to other parts of the hospital, such as Newborn Services (NBS), restocking, checking for expired stock, and weighing babies prior to discharge.

Table 3: Other types of tasks completed

Task	n (%)
Assisting mothers and other family members to other parts of the hospital e.g., NBS, radiology, car park	7 (58.3)
Weighing baby	3 (25.0)
Restocking and checking for expired stock e.g., draws, trolleys, milk room	6 (50.0)
Maintaining WOWs/ Obs machines e.g., cleaning, changing batteries	1 (8.3)
Making tea/coffee for women/families	2 (16.7)
Printing resources for NESB women/families	1 (8.3)

NBS= Newborn Services; WOW = workstation on wheels; Obs = observation

Midwives

Characteristics of midwives who completed the survey

A total of 74 midwives completed the survey. Characteristics of the sample are reported in Table 4. Most participants were aged under 34 years, and all were female. Approximately 70% had been registered as a midwife for four years or less. About 80% of the midwives were employed at Western Health for 5 years or less and most of them intended to continue working at the service for 3 years or more.

Table 4: Characteristics of midwife participants

		n (%)
Age	18 - 24	12 (16.2)
	25 - 34	41 (55.4)
	35 - 44	10 (13.5)
	45 - 54	8 (10.8)
	55 - 64	3 (4.1)
Sex	Female	74 (100.0)
Length in years as registered midwife	< 2 years	22 (29.7)
	2 - 4 years	30 (40.5)
	5 - 9 years	12 (16.2)
	10 - 14 years	7 (9.5)
	15 or more years	3 (4.1)
Length of employment at Western Health	< 6 months	2 (2.7)
	6 months to <1 year	13 (17.6)
	1 - 2 years	23 (31.1)
	3 - 5 years	22 (29.7)
	6 - 10 years	11 (14.9)
	> 10 years	3 (4.1)
Length of time intended to continue working at Western Health	< 6 months	2 (2.7)
	6 months to <1 year	3 (4.1)
	1 - 2 years	7 (9.5)
	3 - 5 years	20 (27.0)
	6 - 10 years	19 (25.7)
	> 10 years	23 (31.1)

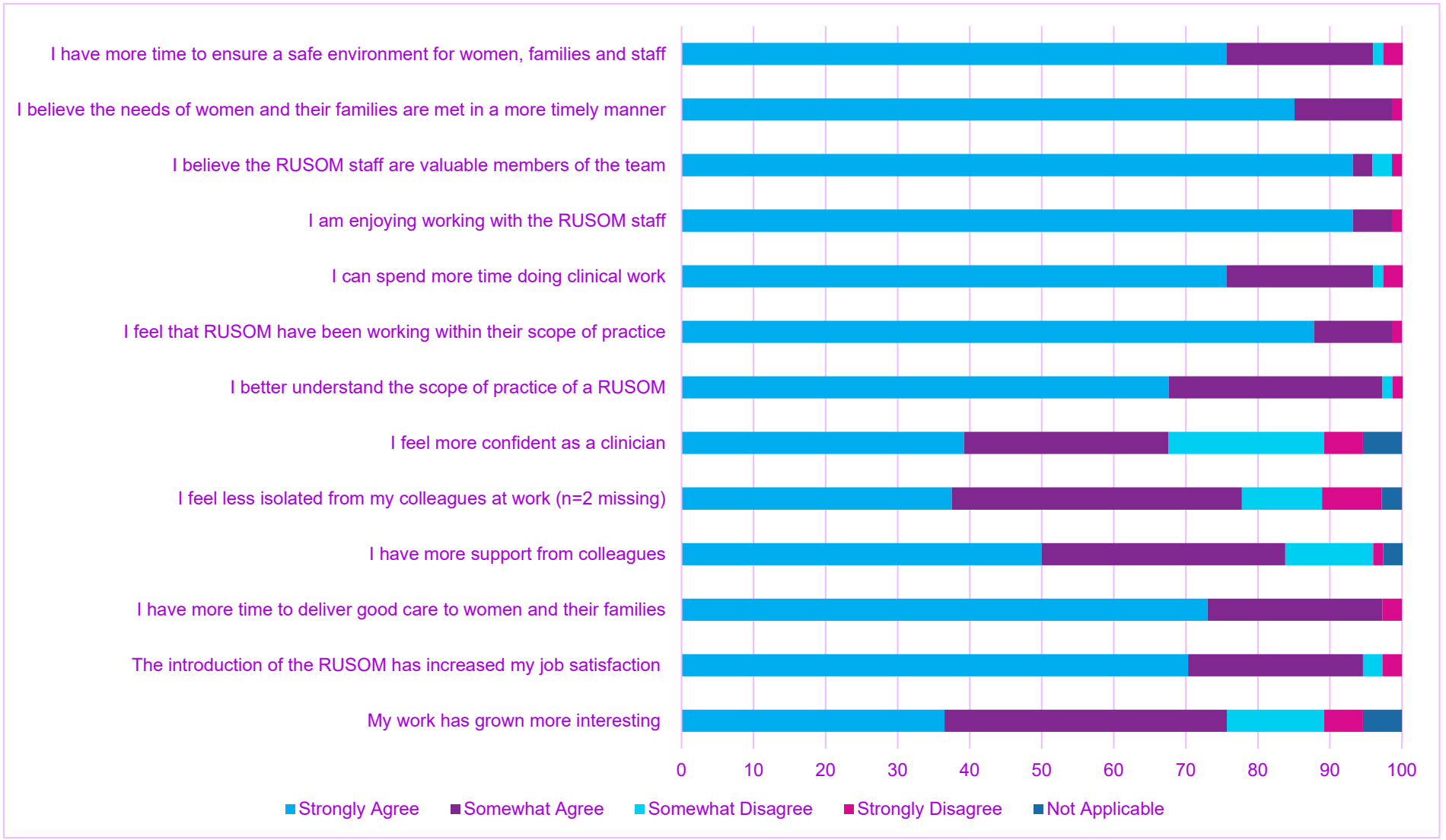

Figure 2: Midwife work satisfaction since introduction of RUSOM

Experience of work and job satisfaction four months post implementation of RUSOM

As shown in Figure 2, over 90% of midwives who responded to the survey agreed that having RUSOM staff on the postnatal wards increased their job satisfaction. About three quarters of the respondents agreed that the introduction of RUSOM made their work more interesting. Most midwives agreed that the introduction of RUSOM allowed them to demonstrate their worth at work, increased their enthusiasm, and made their work more meaningful.

Overall, midwives agreed that their experience of work in a range of areas improved since the introduction of the RUSOM. More than 60% agreed that they felt more confident as a clinician. Most participants agreed that the introduction of RUSOM staff allowed them more time to focus on clinical work, supervision, discussing clinical problems, and delivering good care to women and their families. Many midwives also agreed that the support from RUSOM allowed them to function better on a busy ward. Just under 80% of the respondents agreed that the introduction of RUSOM instilled a greater sense of belonging, and reduced isolation within the team.

The scope of practice of the RUSOM was mostly understood by the midwives, with over 60% indicating that they strongly agreed, and 30% somewhat agreed that they were aware of the RUSOM scope of practice. Almost all the participants strongly agreed that the RUSOM are valuable members of the team and enjoyable to work with. All but one of the midwives agreed that the RUSOM were working within their scope of practice and that the needs of women and families were met in a timelier fashion since their introduction to the wards.

Women

Women's experiences of care provided by RUSOM

A total of 49 women completed the survey. As shown in Table 6 women reported high ratings regarding their experiences of receiving care from the RUSOM. None of the women responded with negative ratings (i.e., poor, or very poor) on any of the response options. Most women indicated that the RUSOM were very good at treating them in a polite and respectful manner and were welcoming of their family and friends. Most also reported that the RUSOM were very good at meeting their overall emotional, educational, and support needs. The women also rated the provision of infant feeding and settling advice highly. A moderate proportion of women responded that certain items were not applicable to them as they had not experienced care from the RUSOM in that context, this included the welcoming of family and friends, and information regarding feeding and settling.

Table 5: Women's experiences of care provided by RUSOM staff

	Very good	Good	Neither good nor poor	Not applicable
How would you rate the politeness and courtesy of the RUSOM?	48 (98%)	1 (2%)	0 (0%)	0 (0%)
How would you rate how well the RUSOM treated you with respect and dignity?	48 (100%)	0 (0%)	0 (0%)	0 (0%)
How would you rate the way the RUSOM welcomed friends and family visiting you?	27(55%)	1 (2%)	0 (0%)	21 (43%)
How did you find the care from the RUSOM?	45 (94%)	3 (6%)	0 (0%)	0 (0%)
How would you rate the responsiveness of the RUSOM in meeting your needs?	47 (96%)	2 (4%)	0 (0%)	0 (0%)
How would you rate the emotional support from RUSOM during your stay?	41 (84%)	3 (6%)	0 (0%)	5 (10%)
How would you rate the information provided by the RUSOM about feeding your baby?	28 (60%)	2 (4%)	0 (0%)	17 (36%)
How would you rate how the RUSOM made you feel about the decisions you made about how you wished to feed your baby?	27 (57%)	2 (4%)	0 (0%)	18 (38%)
How would you rate the consistency of the advice given to you from your RUSOM and other health professionals about feeding your baby?	30 (64%)	1 (2%)	0 (0%)	16 (34%)
How would you rate the information provided by the RUSOM about settling your baby?	23 (50%)	1 (2%)	0 (0%)	22 (48%)
Overall, how would you rate the care you received in this ward and after your baby was born?	39 (81%)	8 (17%)	1 (2%)	0 (0%)

Types of support provided to women from RUSOM

The most frequent type of care tasks received by women from RUSOM (Figure 3) included spending time talking (98%), answering call bells (69%), baby bathing (67%), and support with baby settling (66%). Other common tasks conducted for women included provision of information regarding maternal and infant health (66%), feeding support and guidance (62%), and attending to bed linen changes (56%).

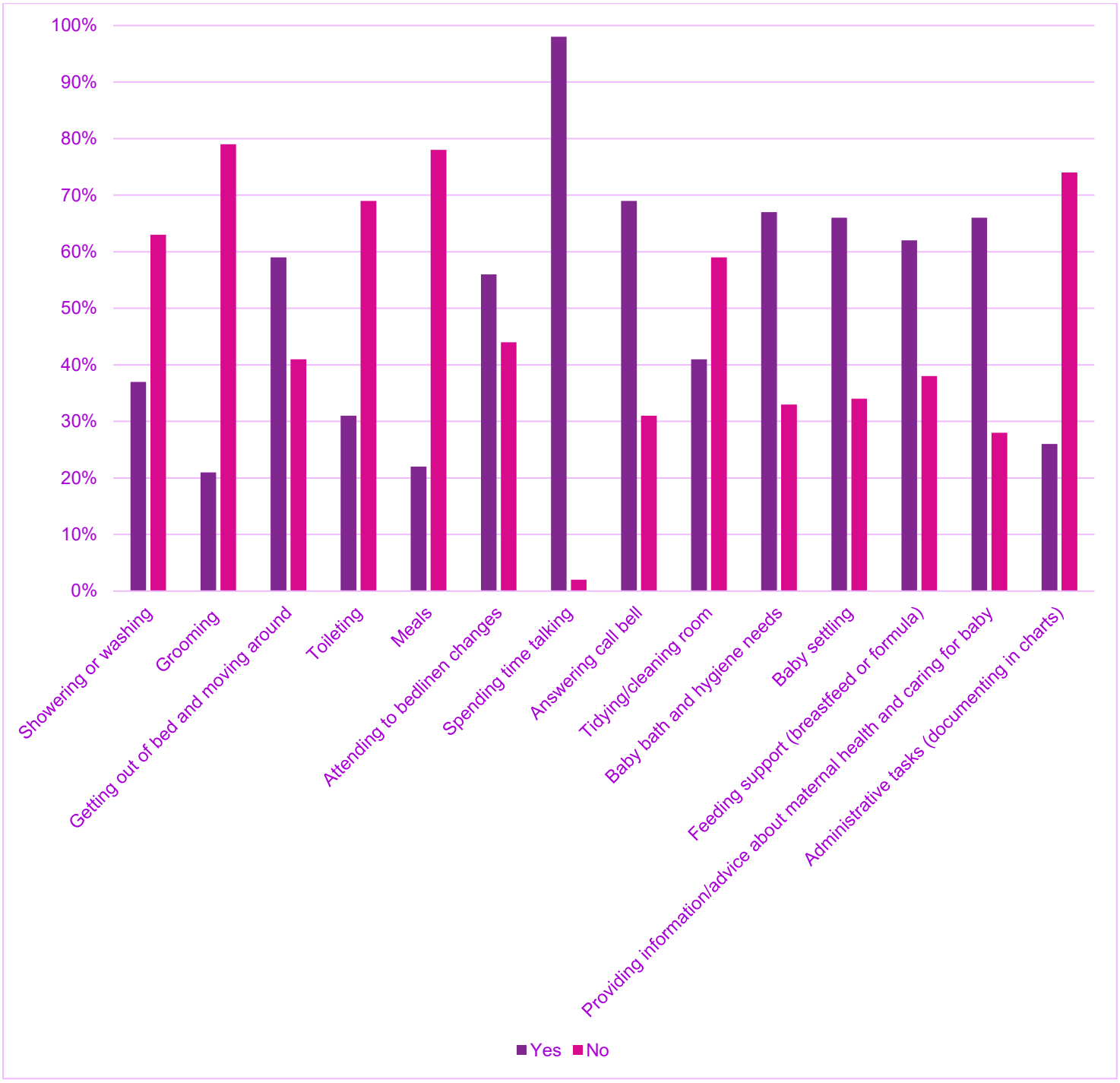

Figure 3: Types of support women received from RUSOM staff

Results- Qualitative

Thematic analysis of the focus group data and open text box comments of the survey data that was collected from RUSOM staff, midwives, midwifery managers and women identified three major themes. These were (i) getting everyone 'onboard', (ii) getting the 'hang' of the RUSOM role, and (iii) reciprocity of the role. The 7 sub-themes for each major theme are presented in figure 4 below. Themes and related subthemes are supported by verbatim quotes presented in italics from focus group/survey participants including RUSOM staff, midwives, and midwifery managers. For brevity, removal of non-relevant segments is indicated by an ellipsis and square brackets indicate words added by the authors for clarity. T1 represents time point one focus group at commencement and T2 represents time point two at six months post commencement, R is for RUSOM, and M is for a midwife, and W is for woman.

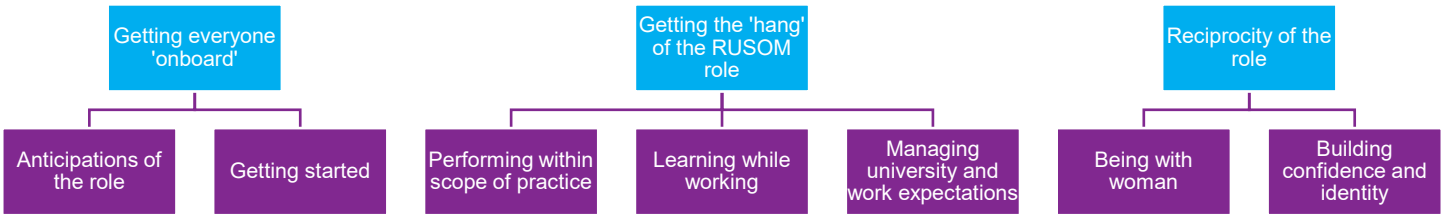

Figure 4: Themes and sub-themes

Figure 5: Exclusive breastfeeding rates on dischargeFigure 6: Themes and sub-themes

Theme 1: Getting everyone 'onboard'

The initial expectations and experiences of implementing the RUSOM role was reflected in the first theme which included the subthemes 'anticipations of the role' and 'getting started'.

Anticipations of the role

RUSOM staff were excited at the prospect of commencing their roles. They were motivated to apply because they wanted to develop more experience, and had had positive placement experiences at the service in the past as one RUSOM highlighted,

> *I've had a lot of placements here, so I already knew a bit of the team, the educators, and they've all been very lovely, and so when the spot came up, I'm like 'this is perfect'. I've always enjoyed my placements here, it's great to get a bit more experience. (T1 FG R)*

A few had not had placement at the hospital before, however, they were inclined to apply due to the strong reputation the service had and wanting to experience the environment. Many of the RUSOM staff felt that undertaking the role would build their knowledge and confidence, as well as put them in a good position for obtaining a graduate midwifery position. As one RUSOM said,

> *I think the confidence thing is really huge and going into grad[uate] year the experience we're going to receive … [the] consolidation of foundational skills of communication, which sometimes we don't*

> *have time to do whilst we're on placement because we're following the midwife around, and Joan Kirner is a brilliant hospital, you hear wonderful things about Western Health as a whole, but that was the other thing … I really just want to see what it's like. (T1 FG R)*

Midwifery staff also anticipated the role with excitement and welcomed the opportunity for support on postnatal wards. As one midwife said,

> *When I read the emails, [about the RUSOM role I thought] oh 'this is great, this is really good'. You know they can help us with things that sometimes we don't have the time, or we feel a bit rushed that we need to get done. I think the [help with] baby baths, because that sometimes can be quite time consuming ...' (T1 FG M)*

Getting started

Midwifery managers reported that their limited involvement in planning of the roles left them little time to prepare for implementation and initially increased their workload. The onboarding process led to confusion around contracts and rostering, which added burden to the management team, as one manager explained,

> *I think the only main feedback that I would have is there wasn't much operational involvement for this professional implementation, and when it comes down to firstly the business case was incorrect therefore all the contracts were incorrect, and that had to be all rectified right up through the channels through to the CEO before I could even process a contract. And you know yes because we weren't involved, we didn't have much time to…forward plan what that looks like, plan…how we are meant to be flexible with their leave without pay, and I think that took us a good 6 months to really work through as a unit manager. Because whilst they [the RUSOM] were, they are amazing, and they're so beneficial and we love them, our workload increased dramatically. (T2 FG M)*

RUSOM participants reported that they experienced a positive transition to the workplace, and that they valued the orientation and support they received from the clinical education team and managers. As one RUSOM said,

> *I think the orientation we got for the RUSOM position was, I felt like it was a bit more in depth [than as a student], and everything was explained to us more thoroughly, and I felt much more confident afterwards. … I also felt like everyone genuinely was very interested in the new RUSOM role and they had that genuine care, and you know, they just wanted us to do well, and so I felt like that extra effort was put in. (T2 FG R)*

The RUSOMs acknowledged and understood how the RUSOM position differed from that of a student and reported that they appreciated the clear delineation between the two roles. A RUSOM noted, *'although I still feel a little bit like a student, I do feel like I am contributing, and I feel like I'm helping. It is different to being on placement, in a good way'* (Survey R). RUSOM staff felt welcomed by the midwifery team, and though there was initial uncertainty reported from midwives about the RUSOM scope of practice, and RUSOM staff indicated they had received some inappropriate requests, this was short lived as understanding of expectations improved as the positions were rolled out onto the wards, as one RUSOM participant explained,

> *… at the beginning there was a lot of uncertainty between the midwives and us of what we could and couldn't do, but I feel like I've been warmly welcomed, and I really feel a part of the team and I'm really keen to continue on with Western Health, because I've just had such a positive experience working there. (T2 FG)*

Theme 2: Getting the 'hang' of the RUSOM role

How the RUSOM role was experienced and developed overtime was described in the second theme which included the subthemes 'performing within scope of practice', 'learning while working', and 'managing university and work expectations.'

Performing within scope of practice

The majority of RUSOM staff indicated that they appreciated the scope of practice of the role as it centred on woman-centred care and did not rely on clinical decision skills. One RUSOM reflected,

> *I'm pleasantly surprised, I think everything that I had imagined was just reassured today. … because we're obviously not registered, we're also not working here as a student, so I knew it was going to be like fitting in between, so it's really nice to actually see the list and be reassured that everything I thought of in my head is confirmed, and we do have a really clear scope, and things like obs[ervations] that I thought maybe we'd be doing, but I'm glad that we're not going to be doing those things because I feel like that's student role stuff, and now it's really great that we can … build rapport with women and …we're going to obviously be working with so many clients, a wide variety of women, and different backgrounds and cultures, but to them you know, we could make their experience, and they might remember us for the rest of their lives and talk about it with their friends, and talk about how great Western Health is, and you know just like a really important role to have. (T1 FG R)*

The RUSOMs recognised the role enabled them to hone key midwifery skills such as breastfeeding support and baby bathing education as they often repeated these tasks with different women and families. The repetitiveness of some tasks however, such as baby bathing, led to boredom on shifts for some, as one RUSOM explained,

> *I feel like at the start it was pretty much like the 'RUSOMs are here, who needs their baby bath done', and like I remember one shift I did about 6 baby baths and that was like all I did. So definitely at the start a lot of baby baths, but I think as it's gone on and midwives have really understood our role and everything we're capable of, that's when it's extended more onto like the breastfeeding support, formula demos, stuff like that. … [which] helps us with our skills communicating, just having that extra time as a RUSOM because you don't have that patient load waiting, and if you've explained something and be like 'we actually have information sheet, I'll go print it off'. I know one of the girls also like printing off a lot of things in different languages, we have that extra time because we're not worrying about what's our next thing we need to tick off. Which is very beneficial to the women. (T2 FG)*

A few RUSOM staff identified that they had participated in MET call experiences, and while this caused some degree of anxiety, they appreciated the opportunity to support midwives and women during these times. One RUSOM explained her first experience of being involved in a MET call,

> *…the first one was terrifying, but it's fine… I think I've had one woman actually faint but she was sitting, but I've just pressed staff assist, handed over when the midwives have come in, and then just kind of stayed with the woman, which I think is really nice because as a midwife we won't be able to do that,– so usually midwives go and get all the stuff they need and I just hang out with the woman, let her know everything's okay. A lot of the women start panicking about their baby, especially if their baby's crying or is due for a feed, so I'll grab the baby so it's right next to her, keep her updated, update the partner, yeah that's basically the main role. If I hear an emergency buzzer or an assist go off and I'm second in the room, I'll just ask the midwife…are you good in here, can I do anything, and that's as simple as like grabbing an obs[servation] machine or a wheelchair or something.*

In such instances, midwives and managers noted that the RUSOM staff acted promptly to escalate the care of the woman and provided support that was within their scope of practice, whilst the clinical team attended to the emergency at hand. This was highlighted in two comments made by managers below,

> *I've actually found there's been a couple of incidents where…they've been in a situation where they've had to call for help and they've always escalated it appropriately. Like they've gone to get a woman up to mobilise during a shower, {and they faint] they've always acted appropriately to escalate that. (T2 FG M)*

> *A woman fell in the bathroom after a Caesar[ean birth], and it happens, and one of them came in and she was helping to move the bed so that we could get her back onto the bed and going to get some extra sheets, she was still handy in that situation. (T2 FG M)*

As the role evolved, some tasks were added to the scope of practice for the RUSOM role and other additions were being considered. Some RUSOM staff and managers welcomed the prospect of expanding the scope of practice, a few RUSOM were confident that tasks such as catheter removal and transcutaneous bilirubin (TCB) assessment of neonates could be added to their task list and avoid unnecessary time wasting, as one RUSOM explained,

> *It's a tricky one but I feel like as third years you can't really do it wrong, I think taking out catheters, just for me personally, you have day one Caesars [caesareans] getting up and a lot of the midwives do it either when they're in the shower or after, so we've already got this woman up and she's standing in the shower or is completely naked and then you're asking someone else to come in and do it, and I just feel like the catheter thing just adds a little bit extra. And I feel like you can't really get it wrong taking a catheter out, unless you obviously…don' t take the 10mls out. But for me that'd be the one thing, and it would make getting day one Caesars[areans] up so much easier because sometimes it's delayed because the midwife is busy and can't come and take the catheter out, and the woman wants it out now. (T2 FG R)*

Other RUSOM staff were, however, concerned that the additional tasks being considered (such as catheter removal) would require greater decision making and accountability, which made them feel uneasy.

> *I personally don't feel comfortable doing it, I just feel like it's a bit of a hard one, I know I can do it, I take catheters out all the time, but I think adding that extra responsibility to the RUSOM in terms of holding that space… I'm more than happy to wait for a midwife to come in… the woman's in the shower with the bag, and then I just phone them at the end of the shower to be like okay we're getting out of the shower now and they literally come in like 2 seconds, just check and make sure everything's been going okay and then they leave…that's not my patient load, I'm here to help out, but…I'm clinically not responsible for that woman, so I just feel like I personally wouldn't feel comfortable doing it. Just like I shouldn't be checking pads, I'm happy to go get a pad for a woman… we shouldn't be measuring loss and doing pad changes because that should be the midwife that's looking at that to get that clinical picture of how much loss the woman is experiencing (T2 FG R)*

Extending the scope to include other maternity areas within the hospital was also welcomed and was perceived to be of value in the provision of support to the service as well as the RUSOM themselves in developing more experience. As one RUSOM indicated,

> *It would be interesting to see if our skill set could be used and benefitted in other areas of the maternity setting, specifically postnatal care in the home. Often domiciliary midwives are run crazy off their feet, it would be great for these midwives to have an extra set of hands to help them with postnatal tasks, still within our scope. (Survey R)*

RUSOM staff, midwives, and managers agreed that the RUSOM staff required access to their own ward phone so that tasks requests could be received in an appropriate and timely manner. Some RUSOM staff indicated that they were

asked to use their personal mobile phones for work purposes, and they felt this was unprofessional and encroached on their privacy.

> *I didn't feel comfortable putting my mobile on the board, like I was just like 'no that's not professional', and I'd heard my friend who's a midwife at the hospital say 'oh my gosh I felt so horrible, I called a RUSOM on her mobile and she was already at home', and I was just like 'no'. I don't really like it, and then that whole aspect of if you're answering it in front of a family… this looks really unprofessional, I'm like this is a work thing, I personally don't like it. So, I feel like moving forward that's probably like the one thing I would say is an issue, I feel like having a dedicated phone for the RUSOM would be very beneficial. (T2 FG R)*

Learning while working

As the role continued over time, RUSOM staff reflected that having continuity of their work experience in comparison to short blocks of student placement allowed them to develop and refine their skills and learn from observing the practice of midwives they were supporting. As exemplified by the comments made by these RUSOM staff below,

> *I feel like this is additional experience to what I've already received, and I think it does come back to that continuity as well… I feel [as students] we do get plenty of experience, but it's all bunched together and then you've got a big break in between so this allows us to maintain our skills throughout the year. (T2 FG R)*

> *So, like breastfeeding, [as a student] you wouldn't talk about the perfect positioning, you wouldn't spend the time to actually show them, and do it for them. Whereas, as a RUSOM you literally can stay in the room the whole breastfeed, whereas, as a student you don't. So, just helping them latch on, or even with baby baths, you can take the time to talk through the whole thing, rather than rush it. And with formula prep[aration] as well, like teaching them how to actually do it and showing them, whereas I found as a student you don't usually do that, you just go into the room, do it yourself, and then just give it to them. (T2 FG R)*

RUSOMs also valued the autonomy of the role which meant they could practice their skills free from the pressure of assessment. One RUSOM felt because of this, she was able to gain more independence,

> *I think something that I've learnt is just how to be an independent practitioner, and it's very different to being on placement where you're constantly under the watch and supervision of somebody else. And something that actually kind of surprised me… I actually think I work better, and I interact better with women when I don't feel the pressure of eyes constantly on me. And… because I feel confident… as a RUSOM is within my scope and so I feel relatively confident with that now. I feel like, you know, if I'm doing a baby bath, I know what I'm talking about, I know how to do the baby bath – however, if there's someone there watching me I feel like it's just the pressure and I'm just like you know there's someone watching me, 'am I saying this correctly, would they say it differently?' (T2 FG R)*

The RUSOM staff acknowledged the support they received from midwives and managers. They reported that they were always responsive to their questions and helped them to understand the requirements of their roles and supported their learning, as the following RUSOM said,

> *…the unit manager's have been… really helpful… they were literally an email away and like that's fine sort of thing and respond within 24 hours all three of them, [one manager] actually would be a half an hour minimum kind of person. I actually had a meeting and she'd apologise for not responding sooner, and you kind of think 'are you serious … like I'm happy to wait however long for a silly question'. But no that's just her personally, which is lovely, but even they're transition I think has been great and they're really approachable… if they're in their office, you can just go and ask a*

question, it's you know 'come in' sort of thing, 'that's okay, sit down', like 'is everything alright?'… they're really caring… (T2 FG R)

Managing university and work expectations

RUSOM staff indicated that managing university and work was challenging at times, however, the flexibility of the role and ability to take time off for university related placements and exams made the juggle manageable. One RUSOM said,

…something I've actually enjoyed about this job is that it has been shorter shifts. I like the 6 hours, and I actually like the fact that we still have our weekends, and that's not even for a social aspect, but it is because I think your final year of uni[versity] is quite intense, and it's heavy, and there's a lot more placement, a lot more responsibility, and it's very very stressful, even applying for jobs, and everything happens in the final year. So having… the shorter shifts and the Monday to Friday has actually worked really well for me personally, and I found that it helps with that work life balance. Whereas, if it was weekends as well, and if they were 8 hour shifts, the shifts really would take up my whole day – whereas right now if I have a morning 8 to 2 I'm home by 2.30, 3 o'clock, I've still got the rest of my day to… do assignments or… even attend uni[versity] classes. So, I think whilst I can see the benefits to extending the role, and whilst I think it can be a positive change, I can also see that that might be slightly challenging for the future RUSOMs juggling the work life balance in their final year of uni. (T2 FG R)

Some did however, report that the restricted work hours and days of the role were limiting. For example, not being able to work on weekends or evening shifts meant that they could not obtain an income when on student placement. As another RUSOM indicated,

I'm actually the opposite, when I had placements Monday to Friday it meant for the 6 weeks, I was on placement I couldn't work at all, and I know that it's probably not good to work 6 days a week, but I have to pay rent. So, it would've been nice to do a placement Monday to Friday and then do like a Saturday PM, only 6 hours gives you a little bit of extra money. I get work life balance is really important, but I feel like sometimes as a student it just kind of goes out the window and you just have to hold on for dear life and see what happens. Especially going into our next placement block, which is potentially for some people like 320 hours, that could essentially be like 8 weeks of no pay. So, just for me personally, I would've loved to have weekend shifts, and a lot of the midwives… were, not annoyed, but also expressed really wanting us there on weekends. (T2 FG R)

Planning and using leave for university placements was also a challenge as university timetables were often released at short notice. A RUSOM wrote in her survey response, '*I have had some difficulties in terms of rosters and swapping/covering shifts, have found it impractical to provide availabilities months in advance when uni[versity] classes and placements times aren't available to us yet.*' Providing leave at short notice was also a challenge for managers as the provision of a replacement RUSOM was difficult in the way the role was set up. They agreed that employment on a casual basis would work better, but felt lack of support from a midwifery manager if placed in the casual pool as opposed to a specific ward would not be ideal, as the following manager detailed,

I think all of them have just been notified of their placements coming up, and they're all on a published roster, … and a lot of them are doing like 3, 4, 5 shifts a week [but can't on university placement], so that's all their annual leave gone, and then they're applying for leave without pay, it leaves huge holes in the roster. I just sent out an email, and there were probably about 15 deficits in there to see if some of them can pick up the holes in the roster that this has created. I mean I think it would be better to have them employed on a casual basis, but then I wouldn't want them to …fall under the nursing/midwifery workforce unit, because I think they need the support of a manager. (T2 FG M)

Expanding the hours of the role was considered to be of value by the RUSOM themselves, offering them greater opportunity to obtain shifts, and by midwives, to relieve the strain at critical time points when the wards were particularly busy. As one midwife indicated,

> *The hours of the RUSOM needs to change so that they are here until 21:00pm instead of 20:00pm. The time between 20:00-21:00pm is one of the busiest times, and we need more assistance in this time to get the work done before night duty arrive for their shift. It would be good if they were also able to complete other tasks like taking a baby to NBS or taking a patient to another floor. Another suggestion is having the RUSOM on over the weekend, which would be a great help to staff as the floor is always busy. (Survey M)*

Similarly, a number of women recognised the necessity of RUSOM staff to support midwives on the busy postnatal ward, one woman indicated that the role should be extended to night shift, she wrote,

> *All of the RUSOM were lovely. I wish they were available at nighttime, as at nighttime it feels that the midwives are much busier and it would be nice to get help to settle my baby and for someone to help with changing my baby's nappy and getting my baby out of its cot. (Survey W)*

Theme 3: Reciprocity of the role

The mutual benefits of the role to RUSOM staff, midwives, and women were highlighted in the third theme and represented in subthemes 'being with woman' and 'building confidence and identity.'

Being with woman

RUSOM staff repeatedly mentioned that spending time with women was one of the greatest benefits of the role. It offered them the opportunity to provide women extensive emotional support and fully experience the midwifery philosophy of 'being with woman'. The uninterrupted time with women gave them further opportunities for learning, developing their skills of communication, education, and empathy. As the following RUSOM staff said,

> *…so, you get to know them [women] over your shift because you're sort of constantly in and out of those rooms. And I think there's just some people that need that extra reassurance and that extra emotional support that the midwives often don't really have time to give. And so when you do have that time to give, I think they're just like 'oh thank you', like there's finally someone that's able to explain this to me, or someone that's just able to tell me that what I'm doing is correct, and just offering that emotional support as well. And usually afterwards they're just so so grateful… and you can just tell that they're so much happier now, that you've settled their worries and just reassured them and given that extra education or whatever it is that they might've needed. (T2 FG R)*

In addition, as the RUSOM staff had more time to engage, they were able to support women to effectively provide breastmilk for their babies, avoiding the need to revert to formula. One RUSOM spoke about teaching women to hand express breastmilk,

> *…. something that I've done a lot of as well, is hand expressing, which I actually think has been really good both me and all the women. It was a skill that I hadn't practiced alot on placement and so it was something that I personally benefited from, and now I feel like I'm so much better with hand expressing which is great. But I also think, like I've sort of seen it on the ward where there's an opportunity for the mum to do some hand expressing and give expressed breastmilk to the baby, but if the midwife doesn't have time to sit there and teach the woman how to do it, or sit there and help her do it, it's so much easier to just revert to formula, and be like 'oh once your milk is coming in it's so much easier, let's just get baby some formula and we'll just do a top up' and I see that happening a lot. Whereas I think now if we're there and we're able to sit there and teach them to hand express, or even help them for the whole entire time, that can actually avoid going down the*

> *formula path when formula isn't even actually necessary in those situations… I think that's been really helpful for the women as well. (T2 FG R)*

Midwives considered the provision of support from a RUSOM was a fabulous asset to Western Health, ensuring that women received timely and quality care. One midwife wrote about the value of the role and how it allowed her more time to engage in clinical work and complete discharges more quickly,

> *The RUSOM has been such a valuable addition to the team. Due to the increase in demand and acuity of the postnatal ward you simply don't have time to be able to provide as much care and TLC [tender loving care] as you want too. Having another member of the team who has the time to sit and support expressing, teach parents how to bath the baby, and even just get the women a cup of tea, has really helped ease some of the stress and burden on my workload. The RUSOMs are always happy to help with any task and are a joy to work alongside. I definitely feel that the RUSOM enable me to spend my time looking after high risk/complicated women or babies without feeling like I am neglecting my other women, because I know the RUSOM is supporting her and will inform me if the woman needs anything. Having the RUSOM around to help, also makes discharging women quicker because they can help do the baby bath while I finish the discharge paperwork. It's hard to remember a time when we didn't have a RUSOM working alongside us. Employing the RUSOMs has been (in my opinion) the best initiative that has been implemented on the postnatal wards since I started working at Western Health. (Survey M)*

Midwives also noted that the RUSOM were missed when they were not on shift, as they relieved the burden on the midwifery team when they were working. This supported the midwifery team to feel organised and provide better care, as stated by one midwife,

> *The RUSOM have become such a vital part of the midwifery team! They are so helpful to midwives and have been amazing with women and babies. We are very grateful to have them on the ward and their presence is missed when there isn't a RUSOM on a shift. Having the RUSOM allows midwives to provide better woman-centred care and we can prioritise our days much easier with the RUSOM assistance. Please never take this role away, they have become so important to us!!! (Survey M)*

The positive influence of the role for women and staff was noted by a number of midwives, many were enthusiastic about the role continuing into the future, one midwife wrote,

> *The effect has been significant, I think they've made a huge difference to not just the midwives but the women and families as well, it's just an extra pair of hands, extra support, they're absolutely fabulous, and I don't know what we'll do without them, so yeah, it has to continue. (Survey M)*

It was also clear from women's survey responses that the care of the RUSOM staff was valued, they were considered to be kind, knowledgeable, and supportive. One woman reported,

> *She was very polite, approachable, and her information was up to date, she was non-judgemental. She was able to share her experiences which was helpful. She taught me a new strategy for hand expressing which I will take away with me. (Survey W)*

Women also perceived that the RUSOM staff relieved the burden on midwives and allowed for the provision of timely care. One woman appreciated the care she received from the RUSOM, *'She went over expectations, she assisted quickly and gave more information than I expected and I am grateful for that'* (Survey W). Another woman valued having the additional support from a RUSOM, *'having the RUSOM being able to stay with me and help. It was good that the midwives could help me but when they leave the room it was nice to have someone else that could help when my husband wasn't there.* (Survey W)

Building confidence and identity

Building confidence and developing a sense of professional identity were outcomes of engaging in the RUSOM role. Confidence was facilitated by feeling part of the team. The sense of appreciation from staff and women and the provision of support from managers helped to build their confidence. As one RUSOM indicated,

> *I have had placement at Western Health and it is a different feeling I think coming on as a RUSOM, … every time I've walked into the ward the midwives are just so happy to see you, they're like 'oh yes you're here', like 'oh can I already give you something to do?', or they're just like… 'hey how are you? It's just kind of being more of a staff member, which has been great, and definitely everything we've learnt as well so far as building that confidence, and I've even found, just even responding to buzzers on the ward, going in, you just feel so much more confident in the ability to kind of build that rapport with the women quite quickly I think… we're all going to really benefit from moving on with our careers. (T2 FG R)*

The experience of joining the team and developing confidence and skills made the RUSOM feel positive about the service and continuing in a role at Western Health, as the following RUSOM suggested,

> *I feel like I've been warmly welcomed, and I really feel a part of the team, and I'm really keen to continue on with Western Health, because I've just had such a positive experience working there… it's been really good being able to help with building our confidence and building rapport with the women and staff members… I have nothing bad to say… (T2 FG R)*

Many of the RUSOM staff mentioned that the role exceeded their expectations, allowing them to develop their professional identity. One RUSOM identified how various elements of the role helped her to make connections between theory and practice, building her knowledge and professional development. She said,

> *I just love the RUSOM role. It is actually a midwifery student's dream come true. Doing this kind of work is the reason I was drawn to midwifery in the first place. I feel as though I've gotten to a place where I feel quite skilled in breastfeeding support and am actively making a difference in women's lives. I also love the focus on being emotion support, being there to debrief about birth and hospital experiences. I feel as though this kind of work is so important to helping women and their families feel safe in the healthcare environment. There have been a few times where families have shared with me complaints about how they were treated in the birth suite and I was able to connect them with the In-charge to debrief/write a complaint and I really got the sense that they wouldn't have expressed their feelings if I hadn't been able to spend more time with them (which is possible as a RUSOM, but not always as a midwife). I also find I am learning how to translate the academic knowledge I have from university into highly accessible knowledge, and a big part of that is because I work autonomously, so I actually have the space to practice explaining health information (like about breastfeeding) while not being watched, which has really helped me get into a groove with it. The work culture at Western Health has also been super positive, everyone is so nice, helpful, welcoming, and so appreciative, which has really helped with the transition to working within the RUSOM role. (Survey R)*

RUSOM staff anticipated that the role would prepare them for their graduate midwifery year, one explained *'I absolutely love it and really hoping it's setting me up for a graduate position with Western Health'* (Survey R). They also felt it supported their transition to working as a clinician, as one wrote, *'it has been a thoroughly enjoyable role and has made me feel more comfortable about making the transition to working as a midwife'* (Survey R).

The RUSOM staff also supported women to develop their own confidence in becoming new mothers. Women indicated that RUSOM empowered them in their post birth recovery, one mother explaining,

> *Completely happy with her service. The things she did for me were very good for me. She explained things to me that I was not aware about, like she explained the walking is important after birth, and*

she also provided advice about feeding. She inspired me, even though I have a catheter I can do things normally. (Survey W)

Women also identified that the support of the RUSOM helped them to learn skills to care for their newborn babies. One woman reported, *'The RUSOM was very helpful encouraging me and helping with breastfeeding the first few times for my baby, she explained to me reasons why baby would cry, helped me to shower, and helped me to express milk for baby'* (Survey W). Women valued the service from the RUSOMs, and found the role to be a positive addition to their care, as one woman explained, '*I found this service as one of the best… This service is definitely useful for new parents, single mums, and for parents who is not getting enough from parents and families due to this COVID-19 pandemic'* (Survey W).

Data Audit

Data from the exclusive breastfeeding rates on discharge, the number of Riskman entries (potential clinical errors), MET calls (medical emergency team calls) and length of postnatal stay was collected through the usual hospital records.

Exclusive breastfeeding on discharge

The average exclusive breastfeeding rate for Jan to June was 71.9% in 2020 and 70.4% in 2021. There was no statistical significance between the two time periods when analysed showing that exclusive breastfeeding rates were maintained.

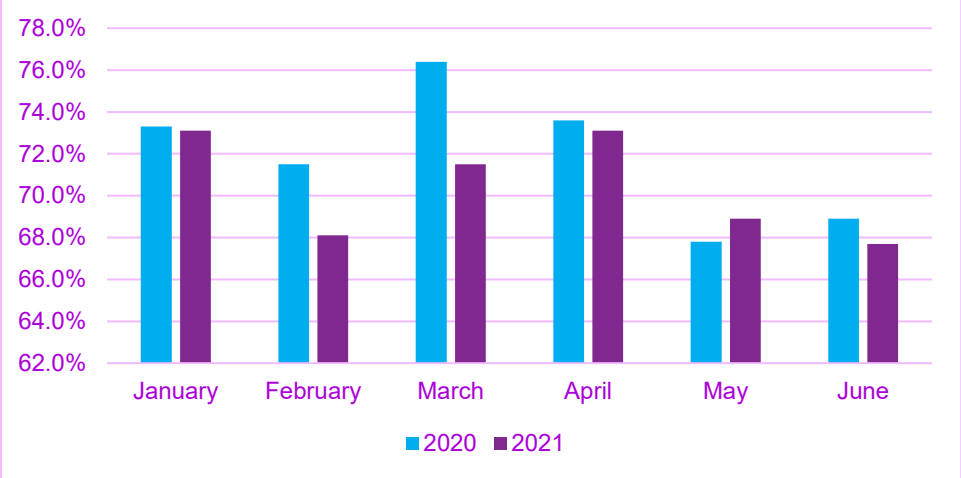

Figure 7: Exclusive breastfeeding rates on discharge

Riskman entries

The frequency of Riskman entries for January to June 2020 and 2021, is shown in table 6. Overall, there was an 11% drop in Riskman entry frequency since the introduction of the RUSOM role. During the T2 focus group, the managers reported that there had been no Riskman entries related to any RUSOM.

Table 6: Riskman entries Jan - Jun 2020 and 2021

Incidents Level 7 & 8		
	January - June 2020	**January - June 2021**
Clinical Incidents	139	135
OH&S Incidents	13	13
Non Clinical/Non OH&S Incident/Issue	29	13
ISR 1	0	0
ISR 2	1	1
ISR 3	117	106
ISR 4	63	54
Total Incidents	**181**	**161**

MET calls

The type and frequency of MET calls for January to June 2020 and 2021, is shown in table 7. Overall, there is little difference in MET call type and frequency since the introduction of the RUSOM role.

Table 7: MET call type and frequency

	Code Green	**Code Pink**	**MET Neonatal**	**MET Paediatric**	**Blue Neonatal**	**Blue Paediatric**
Jan 1 - June 30 2020 Level 7 & 8 JK	1	21	27	2	5	0
Jan 1 - June 30 2021 level 7 & 8 JK	0	25	11	4	3	0

Length of stay

Whilst only one of many variables, the length of postnatal stay was compared before and after the introduction of the RUSOM role. Data was collected from January to June 2020 and 2021 for comparison, as shown in table 8. Whilst length of stay is slightly less on Level 7 than level 8, there has only been minor improvements of 1.8 hours on level 7 and 0.51 hours on level 8.

Table 8: Length of postnatal stay by ward

Year/Ward	Number of Episodes	Total LOS (Hours)	Average LOS (Hours)
2020 Jan-Jun	**7,544**	**353,217.02**	**46.82**
SJK L7 Women's	3,698	171,600.53	46.40
SJK L8 Women's	3,846	181,616.49	47.22
2021 Jan-Jun	**7,849**	**358,580.70**	**45.68**
SJK L7 Women's	3,929	175,474.80	44.66
SJK L8 Women's	3,920	183,105.90	46.71
Total	**15,393**	**711,797.72**	**46.24**

SJK = Joan Kirner Women's and Children's Hospital; L7 & L8 represent the wards

Further consideration was given to the length of stay by days of the week, given that RUSOM only work weekdays at present. Table 9 shows there was minimal difference in discharge time between weekday and weekend for level 7, and 1.23 hours for level 8, with weekends being the longer of the two.

Table 9: Length of postnatal stay by ward and weekday versus weekend

Year/Ward	Number of Episodes	Total LOS (Hours)	Average LOS (Hours)
2021 Jan-Jun	**7,849**	**358,580.70**	**45.68**
SJK L7 Women's	**3,929**	**175,474.80**	**44.66**
Weekday	2,816	125,719.34	44.64
Weekend	1,113	49,755.46	44.70
SJK L8 Women's	**3,920**	**183,105.90**	**46.71**
Weekday	2,794	129,520.62	46.36
Weekend	1,126	53,585.28	47.59
Total	**7,849**	**358,580.70**	**45.68**

SJK = Joan Kirner Women's and Children's Hospital; L7 & L8 represent the wards

Discussion

The aims of this project were to:

- Explore the expectations, experiences, and satisfaction of the RUSOM role by RUSOM staff, registered midwives, midwifery unit managers, and medical staff.
- Understand women's experiences and level of satisfaction with care provided by RUSOM staff.
- Conduct an audit of data related to breastfeeding rates and Riskman incidences (log of adverse events and near misses) on maternity wards, comparing periods prior and post introduction of RUSOM roles.
- Conduct an audit of workforce patterns comparing periods prior and post introduction of RUSOM roles.

It is clear that the introduction of the RUSOM role has been symbiotic for the RUSOM employees, midwives on the postnatal ward, and women in their care. The RUSOM have valued the opportunity to work and learn in their chosen field of midwifery and valued the sense of belonging to the team, and the autonomy they have been afforded in the role. This has enabled them to build confidence and identify as a future midwife, strengthen core clinical skills such as interpersonal skills, communication, breastfeeding support, health promotion, and parent education. Whilst there was varied opinion about the working hours and locations, most RUSOM supported extending the hours available for them to work and the locations in the health service in which they could work. Increasing the workday and hours opportunities would provide better support to the RUSOM when also juggling placement and needing to maintain an income. Little literature has been written on RUSOM staff specifically, however, the findings are consistent with reports of RUSON and similar nursing/midwifery assistant roles which have demonstrated that the additional support provided was welcomed by health services (2, 4, 7, 8, 18). RUSON and similar type staff worked well within their scope of practice, increased work satisfaction of colleagues they worked with, and improved the quality of care provided to patients (2, 5). As stated above, the benefits to the RUSOM themselves have been reflected by other studies (2, 6) of undergraduate nursing/midwifery assistants, showing that having autonomy, building confidence, being part of a team, and involvement in patient centred care helped them to build confidence and professional identity. The RUSOM in the current study also reported that having continuity of experience beyond short blocks of university placements was invaluable and allowed them to strengthen and master skills such as communication, education, and holistic woman-centred care. This is in line with other work which demonstrated that as reported by RUSON type staff, opportunities to develop such skills are minimal in university based placements (6). The Australian Nursing and Midwifery Federation also suggested that ongoing exposure to the clinical environment afforded to RUSOM staff promotes workforce readiness upon graduation (3), which is a valuable asset to health services hiring new graduates.

Some studies (2, 6, 12) have indicated that RUSON/RUSOM type staff did often experience challenges, such as limited understanding of the role from colleagues, and being asked to work outside of their scope of practice. While these issues were also a concern for the RUSOM in the current study, they were short lived as knowledge and understanding of the

role progressed rapidly after it was rolled out. Other studies have reported negative outcomes such as low job satisfaction, high rates of turnover, doubling up of work for nursing staff and limited emotional support for RUSON type roles, however, these were not identified in the current study. The RUSOM noted that the role exceeded their expectations and felt highly satisfied with their work, particularly in the provision of woman-centred care. This may be due to the clear scope of practice given to the RUSOM, which was recommended by studies of midwifery assistants (2, 15, 16), and the allocation of a midwifery manager for administrative and de-briefing support.

Similar to prior reports of RUSON staff, (4, 5) midwives found the introduction of the RUSOM role invaluable in assisting the busy workload they had to manage every day. Indeed, it was frequent for the midwives to have suggested the RUSOM staff should be employed 24 hours per day and 7 days per week to support the service, as well as in different areas of the hospital, not just the postnatal wards. The midwives had confidence in passing on activities such as baby bathing, assisting women to the shower, and infant feeding support to the RUSOM. Similarly, they felt well informed by the RUSOM about the care provided to women and issues that needed their assessment. Most midwives did not want to see the role go and could not remember what working life was like without them! Similarly, a scoping study (18) found that the introduction of similar maternity assistant roles allowed women to receive better care, especially around breastfeeding, running education groups, supporting birthing units, and providing additional care to women from vulnerable groups. They also relieved the strain on midwives, freeing up their time to conduct more direct clinical care, which was also highlighted in the current study. The scoping review (18) demonstrated that such roles could extend successfully to other wards and units as recommended by midwives and RUSOM in the current findings.

Midwifery managers were equally as impressed as the midwives about the positive influence that the RUSOM had to ward activities and the care provided to women and their families. Whilst there were some initial teething issues in getting contracts and onboarding, as well as rostering, these were quickly overcome and the RUSOM role became smoothly operated within the units. The short notice of leave for university requirements was always accommodated, and when no RUSOM was on a weekday shift as a result of this, it was noticed by the staff. Whilst making the RUSOM role part of the casual workforce was identified to ease administrative burden, the managers felt having the RUSOM dedicated to one area and hence one management team provided the support and scaffolding the RUSOM required for smooth transition to the workforce. Such concerns have been echoed by other findings (10, 12-14) which found poor job satisfaction of RUSON type staff who had little support from management.

Women who participated in the survey were overwhelmingly positive about the RUSOMs. They recognised the extra time and attention they received from the RUSOMs compared to other staff and felt respected and listened to by the RUSOM. This was supported by other findings which demonstrated that women valued the care of maternity assistants and services experienced a reduction in complaints from women since introducing maternity assistant roles (18).

The introduction of junior or unqualified staff may come with risks. The clinical data audit or Riskman, MET calls and Length of stay suggest that the introduction has not had any negative effects, but may have contributed to minor improvements in Riskman entries, length of stay, and discharge times. Reduced discharge times have been reported by services with similar roles (18), therefore re-evaluating this aspect once the strain of the pandemic has eased on clinical staff is recommended.

Limitations

We are unable to predict total participation rates, however, all 14 RUSOM participated in T1 focus group, 12 in the midway survey, and 9 in the T2 focus group, which overall provides good representation. Of those unable to attend a T2 focus group – personal emails (not included in analysis) suggested their experience and perceptions were similar to their colleagues who did attend. Regarding midwives, there were 12 midwives who attended T1 focus groups, 74 who completed the midway survey, and 5 who attended a T2 focus group. Due to the COVID restrictions and the hospital being in the highest level of pandemic response, additional T2 focus groups were not able to be held. Anecdotal information however, suggested that no new information from the survey would be gained. Medical staff were also invited to respond to the survey about their experience and perceptions of the RUSOM role, however, no responses were received despite numerous email attempts. This may be to a lack of interest, their busy workload, or even an unawareness of the role. Given there was only one RUSOM working on any given shift, and they spent most of their

time with women, there was likely little or no interaction between RUSOM and medical staff. If a clinical issue arose it was always communicated to the women's allocated midwife who would then engage relevant medical review or advice. Whilst not reported in the findings above, during focus groups, RUSOM staff did indicate that they had minimal contact with medical staff, and when they did, they perceived the staff to have little awareness of their roles on the wards. This suggests that medical staff may require further communication regarding the RUSOM role, and though this awareness is not essential to clinical practice, an understanding of the various roles on wards may enhance a collaborative workplace culture and improve the learning and development of RUSOM staff.

Regarding women, we initially asked the RUSOM to hand out postcards with a QR code for women to complete the survey. This resulted in a very poor response rate. To address this, the Research Fellow would meet with the RUSOMs a few days per week and asked which women they had provided care for on that shift. She then made a personal approach to those women for recruitment, providing a mobile device for completion if the woman was willing to give feedback. We ceased collecting data at 50 women but found one response was incomplete, giving a total of n=49.

The clinical data audits should be interpreted with caution. The breastfeeding data is sometimes inclusive of babies admitted to Newborn Services which is a confounding factor. The reason for MET calls and Riskman entries was not analysed, however, the managers made note that no Riskman entries related to any RUSOM, or care provided by a RUSOM. Riskman entries and MET call data should be interpreted with caution as the introduction of RUSOMs is just one aspect of many that may affect the incidences reported. The length of stay data included a small number of cases with length of stay of less than 10 minutes, which seems unreasonable. During the T2 focus groups, staff mentioned that discharges are often delayed due to waiting medical review and not related to the timeliness of midwifery or RUSOM care.

Conclusion

The introduction of the RUSOM role has had numerous benefits for the service, midwifery staff and the RUSOM themselves. The RUSOM were able to relieve the burden on the postnatal ward, giving midwives more time to engage in direct clinical care. This was able to enhance the support given to women and improved their quality of care. Having a clear scope of practice for the role ensured there were clear boundaries between the RUSOM and the midwife, resulting in the positive satisfaction for the maternity services team. Employing RUSOM staff has the potential to improve the professional development of upcoming midwives, leading to high quality and experienced graduates that are an invaluable asset to a recruiting maternity service.

References

1. Department of Health and Human Services. Registered undergraduate student of nursing (RUSON): Employment and implementation guide. Victoria: Health and Human Services; 2020.
2. McLachlan HL, Forster DA, Ford RL, Farrell T. Addressing the midwifery workforce crisis: evaluating an employment model for undergraduate midwifery students at a tertiary maternity hospital in Melbourne, Australia. Women Birth. 2011;24(4):173-9.
3. Australian Nursing and Midwifery Federation. RUSON employment model Victoria: ANMF; 2020 [Available from: https://www.anmfvic.asn.au/ruson.
4. Department of Health. Evaluation of three Better Skills Best Care pilot projects. Victoria: Department of Health Victoria; 2011.
5. Department of Health and Human Services. Health Assistants in Nursing. Victoria: Department of Health and Human Services; 2015.
6. Algoso M, Peters K. The experiences of undergraduate Assistants in Nursing (AIN). Nurse Education Today. 2012;32(3):197-202.
7. Roche MA, Friedman S, Duffield C, Twigg DE, Cook R. A comparison of nursing tasks undertaken by regulated nurses and nursing support workers: a work sampling study. Journal of Advanced Nursing. 2017;73(6):1421-32.
8. Chow J, San Miguel S. Evaluation of the implementation of Assistant in Nursing workforce in haemodialysis units. International Journal of Nursing Practice. 2010;16(5):484-91.
9. Briatte I, Allix-Beguec C, Garnier G, Michel M. Revision of hospital work organization using nurse and healthcare assistant workload indicators as decision aid tools. BMC Health Services Research. 2019;19(1):554.
10. Butler-Williams C, James J, Cox H, Hunt J. The hidden contribution of the health care assistant: a survey-based exploration of support to their role in caring for the acutely ill patient in the general ward setting. Journal of Nursing Management. 2010;18(7):789-95.
11. Hasson F, McKenna HP, Keeney S. A qualitative study exploring the impact of student nurses working part time as a health care assistant. Nurse Education Today. 2013;33(8):873-9.
12. Hasson F, McKenna HP, Keeney S. Delegating and supervising unregistered professionals: the student nurse experience. Nurse Education Today. 2013;33(3):229-35.
13. Brady DM. An Exploration of Nursing Assistants' Perceptions About Job Satisfaction. Critical Care Nursing Quarterly. 2016;39(4):371-86.
14. Buck DK. Utilizing CNAS at the top of their authorised duties. Sentinel. 2017;36(2):18-21.
15. Brown M, Lees S, Law S, Mills N, McCalmont C. Using support workers to release time for qualified midwives in maternity care. Nursing Times. 2010;106(43):22-4.
16. Hasson F, McKenna H, Keeney S, Gillen P. What do midwifery healthcare assistants do? Investigating the role of the trained healthcare assistant. RCM Midwives. 2005;8(2):74-7.
17. Clarke V, Braun V. Thematic Analysis. The Journal of Positive Psychology. 2017;12(3):297-8.
18. Sandall J, Manthorpe J, Mansfield A, Spencer L. Support workers in maternity services: A national scoping study of NHS trusts providing maternity care in England 2006. London; 2007.

Appendix 1

RUSOM (Registered Undergraduate Student of Midwifery) Core Activity & Exclusion Lists

The Registered Undergraduate Student of Midwifery (RUSOM) works as an assistant to the health care team, assisting Registered Midwives to provide delegated aspects of clinical care. Elements of direct and indirect clinical care will be delegated in accordance with the professional judgment of the supervising Registered Midwife and in accordance with the level of achieved educational preparation and assessed competence of the individual RUSOM.

Clinical assessment of a woman and their baby must be conducted by the RM responsible for delegation

RUSOMs are enrolled at a University and undertaking an entry to practice midwifery degree, registered with AHPRA as a student midwife, and who at commencement of their employment have successfully completed at least two years of a Bachelor of Nursing/Bachelor of Midwifery dual degree or two years of a Bachelor Midwifery Degree

RUSOMs undertake activities that have been delegated and supervised by a registered midwife in accordance with the NMBA Midwife Standards for Practice (2018), NMBA's Clinical Supervision Guidelines for nurses and midwives (https://www.nursingmidwiferyboard.gov.au/) and Delegation and Supervision Guidelines for Victorian Nurses and Midwives (DHS,014) (https://www2.health.vic.gov.au/about/publications/ResearchAndReports/supervisionguide-nurses-and-midwives-faqs).

Registered Midwives can only delegate aspects of care which are consistent with the educational preparation, skill level and assessed competencies of the RUSOM, and the care that is delegated, is identified within the Core Activity List, RUSOMs are not to be given sole allocation of women or babies.

RUSOMs can work shifts of 4 hours or more (morning and evening) and 10 hours (nights), Monday to Sunday.

The following Core Activity List has been developed to assist staff to understand the activities a RUSOM may undertake under the delegation and supervision of the Registered Midwife. In exercising clinical judgment, the Registered Midwives will also take into account the woman and baby's acuity and risk of clinical deterioration.

Core Activity List

Area of care	Activity	Excluded activities
Hygiene	• Assist with personal hygiene of woman • Assist with dressing and undressing • Removal of make-up and nail polish for procedures • Hand-hygiene • Pre-operative site preparation (with surgical clippers only) • Assist with baby bathing and hygiene needs	• Cutting/trimming nails – including babies nails
Toileting	• Change soiled bedding / under pads • Provide, record and empty urinal pans for women on fluid balance charts • Empty and record urinary catheter bag drainage • Document and report lochia and elimination amounts to Registered Midwife • Assist with changing of maternity pads • Assist nappy changing of baby	• Insertion of urinary catheters • Urine specimen collection
Manual handling & Mobility	• Assist with transfers, sitting woman out of bed/on toilet/commode • Assist women to change position in bed • Provide pressure area care • Assist with mobilising women • Assist in the use of manual handling hoists/aids • Transport for discharge • Assist with basic infant cares and settling	• Transport of women or babies awaiting transfer to facilities outside of Western Health
Nutrition	• Assist with safe meal set up, adjusting table and opening packages as required • Provide water/refilling water jugs or making drinks for women • Assist with infant feeding per care plan and women's preferred methods • Document and report to a Registered Midwife nutritional outcomes for the woman and her baby	• Develop or change infant feeding plans • Provide infant feeding advice
Environment	• Ensure falls prevention strategies for mothers and babies are in place – call bell, phone, bedside table in reach, bed lowered, trip hazards removed as per current Safe sleeping guideline • Maintain safe and tidy ward environment. Placing flowers in vases, water changes for flowers/vases • Making beds and cots • Assist safe infant sleeping practices as per current Safe sleeping guidelines	• Checking emergency equipment including resuscitation trolley, bedside suction, oxygen and air
Communication	• Answering call bells including staff assist Reporting and/or escalating all care and any concerns to supervising Registered Midwife • Clerical answering and transferring calls/intercom	• Provide clinical information and advice to women or families • Taking verbal clinical orders from unregulated health care workers, administrative, medical or allied health staff

	• Assist with communication tools for women (iPads/Wi-Fi etc) • Referring all aspects of care out of scope to Registered Midwife • Direct visitors to ward clerk or Registered Midwife for assistance • Immediately report emergencies as per hospital policy • Attend handover and local team • Orientate women and family/carers to ward environment • Seek regular feedback from supervising • Registered Midwives and reflect on practice	• Accepting delegated duties from an enrolled nurse (EN) • Taking verbal pathology results via telephone • Providing advice, counselling, confirming new diagnosis and communicating confidential information
Documentation	• Complete fluid balance chart: Oral input and urine output and report to Registered Midwife • Complete feeding chart for baby • Complete baby weight, document and report to Registered Midwife • Assist in the documentation of valuables • Assist in filling out bedside communication boards • Complete incident reporting as per local hospital policy	• Completing documentation on women on fluid restriction • Documenting in EMR or progress notes/ observation charts • Completing care plan details on communication boards or handover sheets
Maintenance	• Restock supplies and equipment • Cleaning and putting away equipment between use i.e. – infusion pumps	• Restocking emergency supplies in resuscitation trolley • Restocking medicine supplies
Other duties	• Assist packing and unpacking women's belongings when required • Attend professional development sessions Initiate emergency response alarms as per organisational policy • Running simple errands within hospital grounds • Re-application of anti-embolic stockings	• Measurement and initial fitting of anti-embolic stockings • Advanced clinical assessment including – risk assessments, blood glucose levels, urinalysis, collection and labelling of specimens • Care of complex women or babies as defined by Registered Midwife in charge • Medication administration (all routes, including drops and topical creams) • Intravenous therapy management • Oxygen therapy • Suctioning • Wound management • Allocation as the primary midwifery carer for women or babies