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T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

Supporting the Midwifery Team

Assignment 3 - Professional discussion - Distinction

Guide standard exemplification materials

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T Level Technical Qualification in Health
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Supporting the Midwifery Team

Assignment 3

Contents

Introduction

The material within this document relates to the Supporting the Midwifery Team occupational specialism sample assessment. These exemplification materials are designed to give providers and students an indication of what would be expected for the lowest level of attainment required to achieve a pass or distinction grade.

The examiner commentary is provided to detail the judgements examiners will undertake when examining the student work. This is not intended to replace the information within the qualification specification and providers must refer to this for the content.

In assignment 3, the student must reflect on their own practice as a form of learning and continuing development. The student must answer questions and discuss their learning experiences in a professional manner.

After each live assessment series, authentic student evidence will be published with examiner commentary across the range of achievement.

Theme 1: observations, screening and measurements of newborn babies

The questions that follow will be about reflecting on learning or an experience of the routine tests that make up the newborn screening programme.

Question 1

Part A

Referring to your learning or experience, discuss the routine tests that are offered in the newborn screening programme.

Part B

Referring to your learning or experience, explain the roles and responsibilities of the midwifery team involved in delivering the newborn screening programme.

Question 2

Part A

Referring to your learning or experience, explain the rationale for one newborn screening test that you observed or assisted with.

Part B

Justify the need for and importance of informed consent in both this test and in general practice (you should refer to your examples given in part A).

Student evidence

Question 1

A:

The newborn screening programme is a national programme of 3 different screening tests that are offered to all newborn babies. These are routine and offered to everyone to help pick up any problems that might affect the baby's health or development, but the parents can choose whether or not to have them.

First is the newborn and infant physical examination (NIPE), which is normally done in the first 72 hours after birth before the baby goes home. This is a head to toe check of the baby. It specifically looks at the eyes, checking for cataracts by looking for the red reflex when a light is shone in the baby's eyes. The midwife also listens to the baby's heart to check for any heart murmurs and checks the hips to check for clicky or dislocatable hips. If the baby is a boy, it also checks that the testes are descended. If any problems are picked up on the tests the babies will

normally get referred to the paediatricians or get further follow up tests.

Normally when the baby is in hospital, they will get their hearing checked by the hearing screeners. This is done with an automated test where earpieces are put in the baby's ears and a series of automated signals are sent through and the equipment can measure what is reflected back which tells them the baby can hear in both ears. My mentor discussed with me the fact that they try to leave this test as long as possible before the baby goes home before its done to allow the baby's ears to clear of any fluid, otherwise they can't get a clear response. If they can't get a clear response, they can also do another test that uses electrodes on the baby's head, and it picks up the brain's response to the signal instead. Some babies must go back at a later date to repeat the test.

The last test is done on day 5 after birth, so is normally done at home by the midwife but some babies might still be in hospital, for example on special care baby unit (SCBU) so the doctors might do it there. It is called the newborn bloodspot test or heel prick test. A blood sample is taken from the baby's heel on a card. It is looking for a number of very rare conditions the baby might have been born with that could affect its development if they are not picked up. This includes things like sickle cell anaemia, hypothyroidism, cystic fibrosis and several metabolic disorders

B:

When I was in the postnatal ward, I watched the midwife carry out the NIPE test. She had had specialist training to be able to do the test. We talked about the fact that babies on special care would have a doctor carry out this test. The midwife's role was to talk to the parents about the tests she was going to do and get informed consent and check if they had any questions. She also checked whether there was any family history before she did the tests. As she did the tests, she kept the parents informed of what she was doing and of the results, which I think is important. Although she has been trained to do the NIPE, on one baby check she wasn't sure about whether she heard a heart murmur or not, so she got a doctor to check it because it is also her responsibility to get things checked if she is not certain. All documentation and arranging follow up if needed is also part of the midwife's role, so the results are all documented on a computer system and the printout was put in the red book. She showed me different referral letters that could be generated if any problems were found. The maternity support worker might help the midwife prepare the equipment needed to do the tests, like get the ophthalmoscope and stethoscope ready and cleaned and she also asked me to help keep the baby still and calm her when she was listening to the heart and checking her eyes.

The hearing test is done by specialist hearing screeners who have been trained. They must also explain the test to the parents and get consent. It is their responsibility to follow up on any babies who do not pass the test in both ears and make sure they get offered another appointment later after they are home to re-check. They also make sure the results are in the baby's red book so that the midwives/health visitors and GPs can see.

The community midwife normally does the newborn screening (NBS) at home on day 5 but if the baby is still in hospital then the hospital midwife or doctor, or nursery nurse might do the test. It is the role of the midwife here to ensure the test is done on the correct day and to explain the purpose of the test and get consent. The midwife also needs to wash the foot first to make sure the sample isn't contaminated and make sure that they get a sufficient blood sample, so the test card isn't rejected by the labs. She must fill in all the details correctly on the card and document in the red book and her notes that the test has been done. She should also let the parents know that the results come through the post and how long they take.

Question 2

A:

When I was with the community midwives, I watched them carry out the newborn blood spot test on day 5 so I'll talk about that test.

This test is a blood test on the baby that looks for some very rare conditions that they might have been born with. This includes sickle cell anaemia, which is a blood disorder, cystic fibrosis, which is a disease that causes excess mucous in the lungs, hypothyroidism, where the thyroid gland is underactive and 5 different metabolic disorders like PKU.

The rationale for doing this test is that these can all be easily picked up with a blood test and if we find them, we can help manage them. For example, babies with thyroid problems will be regularly checked as they grow and given thyroxine. Babies with PKU will be given strict diet advice about what foods they must avoid. If we did not test for them, they can all affect the baby's health and development.

A lot of parents are a bit anxious about the test but when they understand the importance then they are generally fine to let the midwife do it.

They are very strict that the test must be done on day 5 to be accurate, so if the sample is taken too early then the midwife will have to repeat it again.

Examiner: Can you describe what happened when the test was carried out?

The midwife told the family about the test, what it would involve, what it tested for and why it was important to get informed consent. She made sure the mum had seen the screening tests for you and your baby leaflet.

She washed her hands, which is important before touching a newborn baby as their immune systems are not as good as ours, and she put on gloves.

She asked the couple for some warm water and cleaned the baby's foot to make sure there was no contamination. She said that you aren't allowed to use sterets or alcohol wipes as that can affect the results. If the foot is warm it also bleeds a bit better, so she massaged it a bit first.

She quite often got the baby to try to breast feed first too, as then it would be calmer and not kick around so much, so it was easier to do the test.

It is important to put the lancet on one side of the baby's heel rather than straight in the middle to try to avoid nerves and get a good sample.

The midwife then collected the blood on the card, trying to fill the circles with one good drop of blood. And it must soak through to the back. The midwife said that if there is not enough blood in the circles the lab send them back out to re-do the test, so sometimes I saw her have to use another lancet to get enough blood.

To stop the blood sample getting dirty, when the card is fully filled out and baby stickers put on it, it is put straight in a special envelope that is put in another envelope and sent straight to the labs.

B:

Informed consent is about making sure the parents in this situation have enough information and understanding to help them make a decision about whether they want to have a test, like the NBS test, done or not. It's all part of making sure care is woman-centred.

You must let parents know that all tests are offered to them and advised but they don't have to have them.

Also, for example, if they know what tests are being done, they might decide to have some of them but not all and that should be respected. If they know exactly what is going to happen and what is being tested for, it stops them being surprised later, like getting results through the post for things they did not realise had been tested for.

After I had watched some NBS tests my mentor asked if I wanted to try to explain what the tests were to one lady. It made me realise how difficult it was to explain things in a way that a non-medical person will understand, because if the woman doesn't understand what you are telling her, how can she consent to it?

It is important for the NHS Trust too that you can show you got informed consent, by making sure that you have documented it. Otherwise, parents could take the trust to court if they think tests have been done on their babies that they did not know about.

Examiner: Is there anything else you would like to reflect on before we move on to the next theme?

I think watching the midwives talk about the tests and get consent has made me realised how important it is to ask women if they have got any questions and to check they understand. One lady first said she didn't want her baby to have the NBS test, but when the midwife asked her about it and what she was concerned about, we realised she had misunderstood and thought we were going to take full bottles of the baby's blood away. This made me think about my behaviour in the future and checking women really do understand.

Theme 2: security and safeguarding procedures and protocols to protect the newborn baby

The questions that follow will be about reflecting on learning or an experience of security procedures and protocols to protect the newborn baby.

Question 3

Part A

Referring to your learning or experience, describe the local procedure for newborn baby identification in the maternity environment and what to do in the event of lost or detached identity bands.

Part B

Referring to your learning or experience, outline the importance of the process and purpose of other security measures in place to protect the newborn baby in the maternity environment.

Question 4

Part A

Referring to your learning or experience, discuss safeguarding procedures involving raising concerns in respect of any risks, threats or signs of abuse in the maternity environment.

Part B

Referring to your learning or experience, present a time you interpreted a risk assessment to provide personalised care.

Student evidence

Question 3

A:

Newborn baby identification is taken very seriously in the hospital because there are so many babies together and people coming and going, so it is really important to be able to identify which baby belongs to which mother.

Where I was on placement, this was done with handwritten baby bands.

On the delivery suite the midwife looking after a lady in labour would prepare 2 bands ready for delivery with the mother's name and her NHS number on.

When the baby was born, the midwife then puts on baby boy or girl and their date and time of birth. We then always showed it to the mother to confirm we had the details right.

The baby always must have both bands on before they are moved anywhere, so before they leave delivery suite,

or for example, if they are born by c-section in theatre, then before they go to recovery. That is because babies are often moved in cots so might be separated from their mother for a very short time, so it is to prevent any accidents where babies are switched.

When they get to the new ward the new midwife taking over checks both bands are still on and are accurate, in front of the mother, checking the details with the first midwife and using the maternity notes to double check.

We put the bands on the ankles as they are less likely to get knocked off or scratch the baby's face then. Sometimes they do kick the bands off though, if they have been put on too loosely so then the midwife would need to write a new one out, again checking with the mother and her notes and put it straight on.

If the baby had no bands on when you checked that would be very unusual and the band 7 midwife in charge would have to be told.

B:

As well as baby identification bands there are numerous other security measures in maternity that I saw in the hospital. This is particularly important in maternity because there are vulnerable babies around who could be abducted or hurt. Often mothers are also very tired or in pain and less mobile after birth and so might not be able to monitor their babies as well as other times. Sometimes, babies must be separated from their mothers too, like if they go to special care so then the security measures are even more important.

On all maternity wards I saw that they had locked doors and visitors must ring a bell to come in. They're linked to video so you can see from the nurses' station who is there at the door. My mentor told me how important it is not just to automatically let people in but to check who they are coming to see and what their name is. Sometimes if women have got safeguarding issues, there will be a list of people who are not allowed to visit so that needs to be checked first.

Staff have passes to get in the doors and they all wear staff badges so that the midwives on the ward can identify anyone walking around to check they should be there. We were always told to be very careful coming into the ward that no one followed us through the open door but to politely explain that they would need to ring the bell so the midwives could check they were ok to come in. Most people understood this.

Babies were not allowed to leave the ward at any time except for discharge either, even if the mother went out, to make sure there was no additional risk to the baby and there was never any confusion as to where that baby was.

When mums were going home with their baby too, bands were checked and the maternity support worker (MSW), or midwife would walk out of maternity with the mother and baby and sign them out at the front desk to ensure there was a record as to which mother and baby had left and when. The midwife would then update the bedboard to make sure it was always accurate as to how many babies there should be.

There are trust policies too about things like what to do if a baby is abducted from the ward.

Question 4

A:

Safeguarding is exceptionally important in midwifery and it is important that everyone knows they have a responsibility to look out for any risks or signs of actual or potential abuse to the women or babies and to escalate those concerns.

One example I was involved with in practice was when I was on the postnatal ward, looking after a woman with her first baby.

One safeguarding procedure in the trust is that, if a community midwife or anyone else has raised or identified any

concerns and has maybe discussed or referred the case to children's social services, the woman has a red file in her notes with all the documentation, referral, and child protection meetings all in one place. This makes it easy for someone who has just met the woman to know if there are any potential concerns.

She had a red file because her partner, who was the father of the baby had a history of being very physically abusive towards her, and she had had broken bones before. She had told social services that she had broken up with him and no longer had any contact with him, and that she didn't want him to have any contact with the baby either. Therefore, social services were no longer involved as it was felt she was protecting her unborn child.

During visiting hours however, I saw that a man was visiting her, and I heard him say to another patient that he was the baby's dad and that the baby looked just like him. I was concerned that he was probably not meant to be having contact if he was the dad or that social services were not aware, he was having contact. I also did not know if the mother wanted him there or not, or whether he was being controlling towards her by insisting on being involved.

I escalated my concerns to the midwife. She looked back over the safeguarding documentation to check what was written and raised it with the band 7 midwife in charge of the ward. The midwife also rang social services to raise her concerns and took advice from the trust's designated safeguarding midwife.

Examiner: Can you evaluate your experience in terms of your own contributions to the situation, positive or negative?

I think it was positive that I had read the file and recognised a potential safeguarding incident.

I also reflected on the fact that I didn't directly check with the man or mother whether he was supposed to be there, but I think I was aware of my own limitations in the situation as an MSW student and that my role was to escalate my concerns. I was also aware that if he did have a history of violence that confronting him on the ward might have put the woman, baby, and other women as well as myself in potential danger.

After discussing things with social services, the man was asked to leave and it explained why, but by the co-ordinator and security in the hospital had been alerted first.

B:

When I was on the postnatal wards, one of the risk assessments routinely looked at after birth was the risk of anaemia or low iron for the woman.

This is performed because anaemia can affect the woman and therefore her ability to care for her baby. Low haemoglobin (Hb) can result in extreme tiredness for the woman which will not help her recovery from birth or postnatal mood, particularly as she is likely to suffer from some sleep deprivation looking after her baby anyway.

It can also cause things like palpitations or shortness of breath if she does things like walking up the stairs or trying to go for a walk, and it can make her feel lightheaded too as the body has to work harder to get oxygen to her brain. This can be a risk to the baby through things like light-headedness/falls when standing up with the baby for example.

If a woman's iron is very low, it can also affect things like her milk production.

Risks for anaemia include low iron antenatally, or postpartum haemorrhage (PPH) after birth.

One woman I helped look after had not needed iron during her pregnancy but had lost 1.5 mL blood during delivery. She looked very pale the next day and she didn't feel well, so we took a full blood count (FBC) blood test to check and her iron levels were lower than 100. This meant the midwife could get the doctors to prescribe some iron for her and we discussed the importance of taking it and told her some things to expect like black stools, so

that she wouldn't stop taking it because of worries. I also gave her advice on where to get iron from in her diet.

She was pleased she understood why she was feeling so tired and unwell and that there was something she could do to help herself.

Examiner: Is there anything else you would like to add to your discussions on this theme before we move on to the next theme?

It was nice to feel that I had helped the woman with low iron postnatally and I reflected on the fact that in the future I would always now remember to consider low iron, both antenatally and postnatally where a woman was feeling tired or had other symptoms.

Theme 3: assessing the physical and mental wellbeing of the new mother

The questions that follow will be about reflecting on learning or an experience of assessing the wellbeing of the new mother.

Question 5

Part A

Based on your learning or experience, discuss assisting to prepare a woman for an ultrasound scan, focusing on the procedure and purpose.

Part B

Referring to your learning or experience, recall and explain the preparation, procedure and purpose of a venepuncture, and explain appropriate actions if the venepuncture fails.

Question 6

Part A

Referring to your learning or experience, reflect on a time when you offered a mother and her partner advice or support in an antenatal clinic.

Part B

Referring to your learning or experience, explain the procedures in escalating any concerns about mental wellbeing to the midwifery team during any stage of pregnancy.

Student evidence

Question 5

A:

In antenatal clinic it is often the role of the MSW to help to prepare a woman for her ultrasound scan and I have been involved in this in practice.

There is usually a scan list that the sonographers are working through, so you can see who is next on the list. We make sure we have their hospital notes ready so that the scan reports can be filed straight in there and then we would go to the waiting room and call for the next woman. Women can bring one partner with them, usually the father of the baby, so I let them know they are both welcome and check their names to make sure I have the right person. I then introduce myself as a student MSW and explain that I am just going to get them ready for the scan.

We always get the room ready at the start of the scans, checking they are warm enough and putting the gel

warmers on so that the gel isn't cold when it goes on the woman's abdomen.

I take the woman and her partner to the scan room and ask her to sit on the bed, lowering the height if necessary. I don't get them to lie down immediately because lying flat on your back can make some women feel unwell during pregnancy, due to compression of the vena cava by the pregnant uterus.

I explain the process of the scan, that it is an abdominal scan and that she will always be lying with her partner sat beside her. I will uncover her abdomen and tuck some paper roll into the top of her trousers or underwear to protect her clothes from the gel. I explain that when the sonographer comes in I will turn off the light so that the scan image can be seen more clearly and that the sonographer will put gel on her abdomen and use the probe to scan over the baby. The couple will be able to see the images on the screen. I also explain that the sonographer probably won't talk much to begin with as she'll be concentrating as that can sometimes scare the couple that something is wrong, but that she'll explain everything when she's done.

It is important to ask if the couple have any questions and gain consent for the scan to go ahead.

When the sonographer comes in, I close the curtain and lock the door to maintain privacy and ensure no one can come in.

When the scan is finished, I help the woman to wipe the gel off herself and help her sit up. I take her outside and ask her to wait while we print out her scan report and growth chart and then I take her notes out to her and ask her to book her next scan at the desk for 20 weeks gestation.

The purpose of that first dating scan is to measure the size of the baby to see how old it is and give a more accurate due date than one based just on the woman's last menstrual period (LMP) date. It also checks that the baby looks like it is developing normally so far and in the right place, so not an ectopic pregnancy for example. It also tells us how many babies are present and where the placenta is and if it is low lying.

The sonographer will also offer the woman the screening test to look for some chromosomal abnormalities like Down's syndrome at this scan and explain about that again, as the community midwife normally talks about it at the booking appointment.

Depending on what is found at the scan, the woman may just get another scan at 20 weeks or might get referred to a consultant if any problems are found.

B:

Venepuncture can be done for different reasons in pregnancy, at birth and postnatally. Sometimes it is part of routine screening and risk assessments, such as at booking where women are screened for infectious diseases like HIV, syphilis, and hepatitis B, and blood disorders like sickle cell anaemia, and to find out their blood group in case they need a transfusion and to check whether they'll need anti-D.

Sometimes bloods can be taken to help diagnosis and treatment, like if a woman has itchy hands and feet you might take bloods to look for obstetric cholestasis (OC).

The first thing to do is check that you know which bloods you've been asked to do and that you know which colour blood bottles they need. You would get everything prepared before you start so you have everything you need. On a clean tray you would get the bottles, a needle, vacutainer, tourniquet, steret wipe to clean the skin and clean swabs and plaster.

I would explain to the woman what bloods I wanted to take and check that she gave consent. I also ask women if they want to lie down while I do the bloods or if they're ok sitting up.

To take the bloods I would first wash my hands and put on gloves. Then I would ask to look at both arms and

choose which vein looks best. The I would clean the skin for at least 30 seconds with the steret and put the tourniquet on.

You have to use an aseptic non-touch technique which means keeping everything as clean and free from possible infection as possible by not touching the needle when the protective cover is off and not keep re-touching the vein to feel where it is.

You then put the needle into the vein and hold the vacutainer very still to stop it coming out of the vein. You will see the blood coming into the bottle if it is in the right place and when it is full, then you can carefully pull the bottle out and click the next one in the vacutainer until you have got what you need.

Then you take the tourniquet off and slowly remove the needle and put it in the sharps bin. The woman can put pressure on the wound with a swab until you can put a plaster on it.

Then I would ask the woman her name and date of birth and check its spelling. Then you would fill in the blood bottles and the blood form while she watches and get her to check her details on them. You must be careful because you can put stickers on some bottles, but not the pink one, which you must always handwrite.

If you don't get any blood when you go in with the needle it sometimes means you have gone in too deep and gone through the vein, so in practice I was shown to withdraw the needle very slowly in case you then get it in the right place and it starts to flow. If not, as long as the woman is happy for you to try again you would throw away any used needles/equipment and get new ones and start again in a different vein.

If you still can't, or she doesn't want you try again you can get a doctor or anaesthetist to take the bloods.

Question 6

A:

An example of when I gave advice to a mother and her partner in antenatal clinic was to a teenage couple around smoking.

In the antenatal clinic with the midwife, we saw a young woman who was only 18 and her boyfriend. It was her 28 week appointment, and it was her first baby. She had stopped smoking when she found out she was pregnant, and she seemed to be doing really well.

Smoking is an important public health issue, particularly during pregnancy so it is something that is routinely discussed within the pregnancy, and any smokers or anyone who has quit recently will have their carbon monoxide (CO) levels checked with the monitor.

The midwife checked the woman's CO level, which was 3 and a score under 4 indicates a non-smoker. So, the woman was pleased, and we praised her for how well she had done. I think that is important as it acknowledges how difficult it may have been for her but reinforces that she is doing the best thing for her baby. And if you can make her feel more positive about what she is doing, she is more likely to stick to it.

I noticed her partner stayed quite quiet so while the midwife was performing her palpation and listening to the baby's heart I started chatting to the partner and I asked him if he smoked. He said that he did, that he tried a couple of times to give up, but he couldn't do it, but that he always smoked outside, which he therefore thought was ok.

I asked if he understood why it was something we talk about in pregnancy, and why we also try to get partners to quit smoking. He said that he knew it was not very good for the baby. I agreed and said that smoking in pregnancy, because of the chemicals in cigarettes can cause growth problems and placental problems for the baby, and make still birth more likely, and that even passive smoking had some of those risks. I explained that although smoking

outside the house is better than inside, he would still be breathing out these chemicals hours after a cigarette and breathing them over the baby, and that having a smoker in the household increased the risk of sudden infant death syndrome (SIDS) or cot death.

I asked when he had last had a cigarette and he said an hour ago, so we offered him a CO test. He agreed and his reading was 12, which is considered high and the machine flashes red and beeps faster to highlight the higher score. I think this was good because it really highlighted to him what I had been saying about him still breathing out chemicals even after the cigarette.

I told him that we had a specialist smoking cessation service that saw pregnant women, but also their partners because it was such an important issue in pregnancy, and I offered to refer him. People can refer themselves into the service, but I think they might often put something like that off so if we can offer to help them, I think they are more likely to engage with it. I also reminded him how much money he could save that he would have to spend on the baby if he quit.

He did agree and we put in a referral to the smoking cessation service.

Examiner: Is there anything you learnt from that situation or anything you'd do differently next time?

I had been a bit nervous about talking to mothers and partners about smoking before because I was worried about seeming judgemental or alienating them. But I think in this case I felt that the woman was doing so well, it would be great if her partner could quit too to help her out, and I was pleased that he seemed, maybe a bit embarrassed but, willing to talk about it. It makes me more likely to try to talk to other women about it in the future. I reflected on this with my mentor, and we discussed that if you are quite straight and just give facts to people and explain why it is important people usually are fine talking about it.

I think next time I'd also ask why he had failed to quit last time, what he had found difficult and firstly tell him well done for trying but also maybe involve the mother too, asking what she had found helpful when she was struggling. I think that would have made it more person-centred, thinking about his individual circumstances rather than just telling him what was bad about smoking.

B:

We know mental health problems can be quite damaging to the woman and her relationship with the baby when they happen during pregnancy or in the postnatal period and, unfortunately, we know that mental health problems and suicide are one of the leading causes of death at this time for women too, so it is really important that we know how to monitor and help women.

At booking we ask about any previous mental health problems as part of our risk assessments so we know who might already be having problems or who might be most likely to have difficulties. For example, we know if a woman had postnatal depression with her last pregnancy, she is more likely to need help again this time.

We are told to routinely ask about a woman's mental health and how she is feeling at every appointment because sometimes if you don't ask, women just assume it is not something that you want to hear about and so won't tell you. I think that is why it is always better if the woman has a named midwife that she can get to know over time as I think she is then more likely to feel comfortable to say something. I think that can happen with an MSW too, if you have seen a woman in clinic a few times and then are maybe doing some parent education with her, she might feel that you have built a good relationship and might be more likely to tell you how she is feeling.

If you know a woman, I think it is easier to tell if her mental health is deteriorating even if she doesn't say anything. For example, a woman who is normally chatty and friendly who starts to become quieter and more withdrawn in appointments. So, for example, one woman I saw in clinic with my mentor who was normally quite friendly, wasn't making eye contact with us, wasn't smiling, and seemed very flat. She was just answering questions with short

yes/no answers and it was obvious her mood was quite low. My mentor asked her about it, and she admitted she had begun to feel quite depressed and was worried she wasn't bonding with the baby. My mentor could then refer her to specialist mental health services to try to help.

Some women might have different symptoms like feeling exhausted and being unable to sleep or having less of an appetite too so it's important to really listen to women.

If I was concerned about someone I was working with, it is important not to just ignore it and wait for someone else to notice. I would always ask a woman how she was feeling if I had concerns. Documentation is very important too so that, for example, even if she says she feels ok and doesn't need any help, anyone else seeing her next will know to monitor the situation.

I think it can be quite scary if you are worried about a woman's mood, but it is important to remember that as an MSW (and especially a student) it is not our responsibility to cure the woman's mental health problems but just to recognise them and escalate them to someone senior. So that is likely to be the woman's named midwife if possible but if not any midwife or the band 7 in charge. You should do that as soon as possible and tell them exactly what has made you concerned.

There are other professionals that she could get help from, for example her GP, so you can recommend that she gets an appointment to discuss things, or services like talking therapies or the perinatal mental health team. In the hospital there are also things like the psychiatry team and the consultants. The health visitor will also be involved in her care and can offer listening visits, so it is important to handover your concerns to other professionals involved in her care, but confidentiality needs to be considered and the woman should be aware of what you are doing.

Examiner: Is there anything else you would like to add around this theme before we finish the assessment?

No, I don't think so, thank you.

Examiner commentary

The student responded to the demands of the assessment with a well-planned, logical and structured approach that demonstrated high level thought and analytical processes and reflection, placing woman-centred care at the heart of all responses.

The student consistently showed an excellent depth and breadth of knowledge in relation to midwifery concepts and without prompting discussed how this knowledge formed the basis for their behaviours/skills and decisions and therefore showed a flexible, dynamic approach to care with good problem-solving abilities, and making strong links to practice experiences.

The student showed good self-awareness and understanding of the scope of their own role and responsibilities and provided evidence of reflection in practice with other midwives to further learn and improve.

The student's responses showed a well-developed consideration of professional issues such as confidentiality/safeguarding and how these impact on clinical decisions and behaviours, and there was always discussion of wider issues such as infection prevention and control or health and safety aspects.

There was evidence of very good problem-solving abilities for the level the student is at.

Overall grade descriptors

The performance outcomes form the basis of the overall grading descriptors for pass and distinction grades.

These grading descriptors have been developed to reflect the appropriate level of demand for students of other level 3 qualifications, the threshold competence requirements of the role and have been validated with employers within the sector to describe achievement appropriate to the role.

Occupational Specialism overall grade descriptors:

Occupational specialism grade descriptors*

Grade	Demonstration of attainment
Pass	A pass grade student can: • communicate the relationship between person centred care and health and safety requirements in healthcare delivery, by o demonstrating working in a person-centred way, taking relevant and sufficient precautions to protect the safety and physical and mental wellbeing of individuals o recognising and responding to relevant healthcare principles when implementing duty of care and candour, including the demonstrating sufficient knowledge of safeguarding individuals and maintaining confidentiality o following standards, codes of conduct and health and safety requirements/legislation to maintain a sufficiently safe working environment o demonstrating use of an adequate range of techniques, equipment and resources safely to promote sufficient levels of cleanliness and decontamination required for satisfactory infection prevention and control • communicate knowledge of national and local structures, definitions of clinical interventions, the scope and limitations of their healthcare role within it, by o adequately following current best practice and codes of conduct across relevant boundaries, relevant to assisting with scenario specific, clinical and therapeutic interventions o working adequately as part of a team to assist registered health professionals with delegated tasks and interventions, supporting individuals to meet their care and needs to a satisfactory standard, including maintaining individual's privacy and dignity and communicating effectively, contributing to handovers, seeking help, advice and information, and responding sufficiently to service users views to maintain effective provision of services o gathering sufficient evidence, contributing to, following and recording information in care plans/records relevant to tasks and interventions, structuring these sufficiently to allow understanding in line with local and national legislation and policies, preserving individuals' rights o maintaining a record of professional development with evidence of using feedback to develop knowledge, skills, values and behaviours consistent with sufficient ability to reflect on practice and thereby improve performance adequately

Grade	Demonstration of attainment
	• communicate sufficiently reliable levels of knowledge of the physiological states that are commonly measured by healthcare support workers including why, when and what equipment/techniques are used, by o working as part of a team to use relevant equipment effectively and safely and following correct monitoring processes o calculating scores, reporting and differentiation of normal and abnormal results to the relevant registered professional o applying knowledge of policy and good practice techniques when undertaking all physiological measurements, checking when uncertain and consistent with instructions and guidance
Distinction	A distinction grade student can: • communicate adeptly the relationship between person-centred care and health and safety requirements in healthcare delivery, by o demonstrating flexible and constructive person-centred care, taking appropriate precautions reliably, making sound decisions to protect the safety and physical and mental wellbeing of individuals o alertness and responsiveness to relevant healthcare principles when implementing duty of care and candour, including the demonstration of exceptional sensitivity and accurate knowledge of safeguarding individuals and maintaining confidentiality o commitment to following all required standards, codes of conduct and health and safety requirements/legislation decisively to maintain a safe, healthy working environment o demonstrating proficient use of an extensive range of techniques to promote optimum levels of cleanliness and decontamination required for effective infection prevention and control • communicate knowledge of national and local structures, definitions of clinical interventions, the scope and limitations of their healthcare role within it, by o following current best practice and agreed ways of working highly relevant to assisting with scenario specific, care-related tasks consistently and reliably, whilst fully supporting individuals to meet their care and needs including maintaining the individual's privacy and dignity to a high standard o working adequately as part of a team to assist registered health professionals with delegated tasks and interventions, supporting individuals to meet their care and needs to a satisfactory standard, including maintaining individual's privacy and dignity and communicating effectively, contributing to handovers, seeking help, advice and information, and responding sufficiently to service users views to maintain effective provision of services o gathering extensive evidence consistently, interpreting, contributing to, following and recording information in care plans/records highly relevant to tasks and interventions, structured accurately and legibly and in line with local and national policies, while preserving and promoting individuals' rights o maintaining a record of professional development to develop knowledge, skills, values and

Grade	Demonstration of attainment
	behaviours consistent with ability to reflect on practice enthusiastically, using the feedback to initiate new learning and personal practice development to improve performance with developing proficiency • communicate exceptional levels of knowledge of the physiological states that are commonly measured by healthcare support workers including why, when and what equipment/techniques are used, by ○ working as part of a team to use relevant equipment accurately and safely and consistently following correct monitoring processes ○ calculating scores, reporting and differentiation of normal and abnormal results adeptly, consistently and reliably to the relevant registered professional ○ applying knowledge of policy and good practice techniques proficiently when undertaking all physiological measurements, checking when uncertain, solving problems, and following instructions and guidance with energy and enthusiasm

* “threshold competence” refers to a level of competence that:

- signifies that a student is well placed to develop full occupational competence, with further support and development, once in employment
- is as close to full occupational competence as can be reasonably expected of a student studying the technical qualification (TQ) in a classroom-based setting (for example in the classroom, workshops, simulated working and (where appropriate) supervised working environments)
- signifies that a student has achieved the level for a pass in relation to the relevant occupational specialism component

Document information

The T Level Technical Qualification is a qualification approved and managed by the Institute for Apprenticeships and Technical Education.

Owner: Head of Assessment Design

Change History Record

Version	Description of change	Approval	Date of Issue
v1.0	Published final version.		June 2021
v1.1	NCFE rebrand		September 2021