Welcome to issue 14 of Midwifery Research Review.

We begin this review by investigating the attributes Australian midwifery leaders identify as essential to effectively manage a midwifery group practice. Following on, we look at a comparison of three clinical facilitation models for midwifery students undertaking clinical placement in South Australia. Other topics included in this issue investigate the fundamental needs in freestanding midwifery-led units, training to promote routine enquiry for domestic violence, perinatal mental health care, women’s experiences of threatened preterm labour and pregnancy nutrition knowledge of pregnant women and clinicians. We hope you enjoy reading this review and look forward to your comments and feedback.

Kind Regards,

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What attributes do Australian midwifery leaders identify as essential to effectively manage a midwifery group practice?

Authors: Hewitt L et al.

Summary: This qualitative interpretive assessment used in-depth interviews with eight midwifery leaders to consider the attributes required for effective midwifery group practice managers and how to develop these attributes. The overarching theme was a need to stand up for midwives and women ‘having it’, intrinsic traits of an effective leader; ‘someone with their hand on the steering wheel’ on the day-to-day job and ‘juggling the forces’ that surround group practice; finally ‘helping managers to manage better’ identified a need to be educated and supported in the role.

Comment (MS): Despite compelling evidence of benefit to women and midwives, there has been very little evidence of wide-scale implementation of Midwifery Group Practice (MGP) as a model of care in Australia. Where MGP models are in place they often remain small, and struggle with sustainability issues. The importance of strong leadership and effective management highlighted when discussing introduction of service change and innovation, but little is reported currently on this in relation to the large-scale implementation of MGP. This paper adds to the literature that will inform sustainable introduction of this model of care. The authors of the study interviewed eight established midwifery leaders (predominantly within one state in Australia) to ascertain their views on what attributes a midwifery manager of an MGP needed to be successful in their role. It is clear from the results that a commitment to women and a strong midwifery philosophy are essential. In addition, the ability to form and build strong relationships in order to navigate the complex web of systems and professions to enable care to remain focussed on the woman is essential. The importance of vision and passion was emphasised, but also the need for support and direction. This is possible through effective mentoring and appropriately designed education programs. Clearly more must be done to ensure midwives seeking to take on a leadership role have access to the guidance and support they need. Similarly, we need to understand more from the perspectives of midwifery managers across Australia as to what they need locally in order to be able to effectively steer and manage the wide scale change we need in order to reorient services to enable more women to access care from a known midwife within a caseload model.

Reference: Women Birth 2018;Aug 24 [Epub ahead of print]

Abstract

In this issue:

- Attributes to manage a midwifery group practice
- Clinical facilitation models for clinical placement
- Women’s experiences of miscarriage
- Fundamental needs in freestanding midwifery-led units
- Training to promote routine enquiry for domestic violence
- Perinatal mental health care
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- Effect of hyperemesis gravidarum on lives and mental health
- Pregnancy nutrition knowledge of pregnant women and clinicians

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Comparison of three clinical facilitation models for midwifery students undertaking clinical placement in South Australia

Authors: McKellar L et al.

Summary: This mixed method evaluation examined clinical placement and three models of clinical facilitation in a South Australian midwifery education program, specifically quality of clinical supervision and key stakeholder satisfaction. Survey data obtained from 174 midwifery students, 149 clinical supervisory midwives and eight clinical facilitators identified few differences across the three models in quality of student support and learning opportunities. Students across all three models were regarded as well orientated and prepared for the clinical environment and clinical facilitators were considered supportive, educative and valuable to the students. Clinical facilitators employed in the ‘shared’ model were considered more able to provide support to supervising midwives and better able to maintain good liaison with universities.

Comment (MS): This small but informative study from South Australia provides interesting data that can inform the clinical education model for midwifery students in any jurisdiction. Australian entry to practice midwifery programs requires students to spend 50% of their time learning in the clinical environment. Making this a valuable well-supported learning experience is essential to prepare the future midwifery workforce for contemporary practice. While there are national accreditation standards in respect to the management of clinical practicum in Australia, there is variation across programs as to how these standards are met in terms of clinical facilitation models. This paper evaluates three different clinical facilitation models in one state in Australia to identify which model may result in the best outcomes for students. The results show that despite the actual clinical facilitation model in place, much of the clinical facilitator’s time is spent on administrative duties including managing the roster rather than working with the students. What is interesting in the results is despite the differences in the models of facilitation, students generally had a good learning experience and felt well supported. This is largely achieved within the time they spend working alongside midwives in practice. Currently though little of the clinical facilitator’s time is spent educating or supporting the midwives who are working alongside students. While midwives in the study reported feeling confident in supervising students, they were unsure of different requirements between universities and student goals, which made assessment difficult, suggesting a need for more regular updates. The authors suggest the clinical facilitator therefore spend more time supporting the midwives in order to address the concerns they reported in their ability to effectively teach and supervise students. Before making changes though in how we support midwives in practice to confidently and competently contribute to the education of the future workforce, we must be mindful of the time pressures this places on an already overwhelmed workforce. Teaching students should be an enjoyable and worthwhile part of a midwives role, but they require not just education, but appropriate time and support to take that role on.


“...some healthcare providers added to that”: Women’s experiences of miscarriage

Authors: Bellhouse C et al.

Summary: This study used semi-structured interviews with 15 women to examine the psychological distress experienced after miscarriage and perceived support provided by healthcare professionals. For most women there was significant distress, grief and loss associated with miscarriage. Both positive and negative interactions with healthcare providers were experienced throughout the miscarriage; all women experienced increased distress following negative experiences. Recommendations from the women to improve healthcare provider service include referral to a psychologist and ongoing follow-up.

Comment (MS): This paper provides the reader with vivid insight into the experience of miscarriage as reported by women who have gone through the experience. There is increasing awareness of the loss and grief experienced by women who experience pregnancy loss, but sadly, this paper reports on how the insensitivities of some health professionals caring for women contributed to that loss. While the authors report women who attended a known private obstetrician reported a better experience than those who received standard care in the public system, the message here is that women need continuity, time and compassion. Women need someone to make sure they have appropriate referral to the help and care they need and support not just as they go through the actual miscarriage, but importantly afterwards as they come to terms with their loss. This paper provides a compelling argument to support the need for women to be able to access caseload midwifery services early in pregnancy. Midwives can provide that emotional support consultation and referral back to appropriate services and follow up that women need should miscarriage occur. However, many public caseload models currently wait until women are approaching the third trimester before referral. Regardless of the care a woman accesses, this paper is a good reminder to all of us to work together and place the woman’s needs first. We should not make assumptions about what a woman needs, but listen with empathy and refer accordingly.

Reference: Women Birth 2018;Aug 25 [Epub ahead of print]

Abstract

[For the full text, please refer to the original publication.]
Confidence: Fundamental to midwives providing labour care in freestanding midwifery-led units

Authors: Hunter M et al.

Summary: This hermeneutic phenomenological study conducted in New Zealand interviewed 11 midwives and three obstetricians to identify what enables, safeguards and sustains midwives when providing labour care in freestanding midwifery-led units. Analysis of the interviews identified themes underpinned by the confidence necessary to provide intrapartum care, which is cultivated by believing the unit is an appropriate space for healthy women to labour and birth. Normal labour and birth are commonplace, which reinforces confidence. Maintaining confidence requires trusting relationships in the midwifery team and mutually respectful relationships with obstetric colleagues. Those with less experience may need support when providing labour care in freestanding midwifery units.

Comment (MS): The findings from this important study from New Zealand provide valuable information to operationalise the restoration of rural maternity services in Australia and return birthing to country for our First Australian women. One of the barriers often cited by service providers to enabling birthing services in rural and remote areas is a lack of midwives who are competent and confident to work in these settings. Another is an unwillingness of obstetricians to support these services due to a perception that they are unsafe. This study reports that in order to build confidence, midwives need to be immersed in low-risk settings, where expectation of normal birth is the culture, but importantly where that culture is supported by obstetric colleagues and senior more experienced midwives. It was heartening to read of the confidence-building support provided to a midwife by an obstetrician in this study, reassuring her that when problems arise they can be managed appropriately, confirming to her that birth in small freestanding units is safe. Some midwives reading this paper may feel that anticipating normality may result in missing warning signs and subsequently put women at risk. This is refuted by midwives in the study who are immersed in low-risk settings, who say that seeing healthy babies and good outcomes the majority of the time heightens their ability to detect when things are not normal. The excellent relationships the midwives had with obstetric colleagues, and the provision of on-site obstetric consultation, are all important points for those planning or initiating these services, to take on board. Immersion of the future workforce in these settings is vital in order to build confidence. We should work to ensure that midwifery students and obstetricians in training have the opportunity to experience working in these settings in order to build the interdisciplinary relationships and respect that are essential if we are to provide services that truly put women first.

Reference: Midwifery 2018;66:176-81

Abstract

Effectiveness of training to promote routine enquiry for domestic violence by midwives and nurses: A pre-post evaluation study

Authors: Baird KM et al.

Summary: This pre-post intervention study was conducted to evaluate the impact of training on midwives and nurses (n = 154) with respect to conducting routine perinatal enquiries about domestic violence. All measures showed improvements in knowledge and preparedness compared to pre-intervention scores. Knowledge scores increased from 21.5 to 25.6 (p < 0.001) and level of preparedness increased from 40.8 to 53.2 (p < 0.001). Most participants (93%) had improved preparedness to undertake routine enquiry, but only 24.9% felt their workplace allowed adequate time to respond to disclosures of domestic violence.

Comment (MS): The role of health professionals in responding to Domestic and family violence (DFV) is no longer in dispute, most healthcare clinicians are acutely aware of the health consequences for women and children who are living and surviving in a violent relationship. Yet, for many years the health service has dealt with the consequences of DFV without developing a safe and family-centred response. This particular study by Baird and colleagues examines the longitudinal evaluation of a DFV training program for midwives in three different hospitals within North East Queensland. By adopting a whole of work unit approach and utilising an experiential learning approach, there was an increase in midwives’ knowledge and confidence. However, an online recording system at one site demonstrated that despite the high levels of screening by the midwives, the disclosure and referral rates to DV community agencies remained low. Organisational barriers to the work continued to exist, not least short appointment times and the continued invited presence of partners at all appointments. Such findings would seem to suggest that further research is required to explore whether there is an alternative way to conduct the screening activity, for example, asking about partner and family violence could become part of a conversation, around how the couple interact and express anger and frustration rather than a tick box exercise, where women are just asked a stream of questions about a history of DFV. Nevertheless, despite the low referral rates, the implementation of evidence-based training, joined up referral pathways and staff support processes contributed to a sustained preparedness by midwives to carry out routine enquiry for DFV.


Abstract

Knowledge, confidence, skills and practices among midwives in the Republic of Ireland in relation to perinatal mental health care: The mind mothers study

Authors: Carroll M et al.

Summary: This Irish exploratory descriptive study used an anonymous, self-completed survey to assess 438 midwives’ competence in perinatal mental health care and explored clinical practices for the assessment and management of perinatal mental health problems. The majority of midwives reported caring for women with perinatal mental health problems; however, they reported limited knowledge of perinatal mental health problems other than depression and anxiety. Midwives also reported a lack of skill in opening discussions on sensitive issues such as sexual abuse, DFV and psychosis, and in provision of information to women’s partners/families.

Comment (KB): This paper reports on one aspect of a larger study “the mind mother study”. This aspect of the study was designed to gain a comprehensive picture of midwives’ knowledge, confidence, skills and practices in relation to perinatal mental health care. This was a large study with all registered midwives within the Nursing and Midwifery Board of Ireland targeted for inclusion in the study. A sample of 438 midwives was eligible for inclusion in the study. Midwives were asked to rate their overall skill and knowledge in perinatal mental health on a scale from 1 (not very skilled) to 10 (very skilled). Overall skill was rated low at 4.48 (SD 1.82), which is below the midpoint of the scale. Confidence level was also measured, which again scored below the midpoint of the scale at 4.37 (1.84). The measurement of skill attainment in undertaking a variety of perinatal mental health assessments again scored low. Where midwives reported the greatest skill was in liaising with other practitioners and services and in particular with colleagues. An area which was rated lowest among midwives was in relation to their confidence in developing care plans for women, especially for women who were experiencing extreme perinatal mental health conditions such as experiencing delusions, compulsive behaviour, or hearing voices. Approximately, a third of midwives reported that they have received no education on perinatal mental health, with 45% reporting that there was no perinatal mental health education available within their service. Although the findings from this research would seem to suggest that some midwives have a good awareness of perinatal depression, there is a lack of knowledge and awareness across the range of perinatal mental health condition problems, such as bipolar affective disorder, obsessive compulsive disorder, personality disorders, eating disorders, self-harm and suicidal thoughts, to name but a few. While midwives do not have to be an expert in mental health, similar to DFV screening there is a need to have a sound knowledge and skills base to be able to identify women at risk who may be experiencing any one of a range of perinatal mental health disorders. The lack of knowledge and skill development in this study suggests that there is a need for further knowledge development and training in perinatal mental health care for midwives.

Reference: Midwifery 2018;64:29-37

Abstract
Threatened preterm labour: Women’s experiences of risk and care management: A qualitative study

Authors: Carter J et al.

Summary: In this UK study, 19 women from different risk and demographic backgrounds were identified by a purposive sample approach and engaged in 1-to-1 semi-structured interviews to explore the experience of threatened preterm labour, risk assessment and management. 11 women were at low risk and eight at high risk for preterm birth, all high-risk women were supported by a specialist preterm team. Analysis using the Framework Approach identified four main themes: (1) coping with uncertainty; (2) dealing with conflicts; (3) aspects of care; (4) interactions with professionals. Both low- and high-risk women experiencing threatened preterm labour struggled to cope with uncertainty. Healthcare management can both help and hinder their coping ability. High-risk women were less likely to receive conflicting advice.

Comment (KB): The consequences of preterm birth to the woman, her family and to society at large, remain a personal tragedy and financial burden. Many women who experience symptoms of preterm birth will not go on to give birth prematurely, regardless of this, most women will experience severe anxiety and conflict associated with preterm labour may even increase the risk. Indeed, the emotional feelings of grief and depression were more pronounced for the women than their male partners. Grief and depressive symptoms, but not the emotional experiences of miscarriage (such as isolation, loss of baby and a devastating event), declined with time. Having already had children improved the emotional experience, but previous miscarriage or infertility made it worse.

Reference: Midwifery 2018;64:85-92

Longitudinal study of emotional experiences, grief and depressive symptoms in women and men after miscarriage

Authors: Volgsten H et al.

Summary: This study in 103 women and 78 male partners assessed emotional experience, grief and depressive symptoms one week and 4 months after miscarriage using the Revised Impact of Miscarriage Scale (RIMS), Perinatal Grief Scale (PGS) and Montgomery–Åsberg Depression Rating Scale (MADRS-S) questionnaires. The emotional experiences of miscarriage, grief and depressive symptoms were more pronounced in the women than their male partners. Grief and depressive symptoms, but not the emotional experiences of miscarriage (such as isolation, loss of baby and a devastating event), declined with time. Having already had children improved the emotional experience, but previous miscarriage or infertility made it worse.

Comment (KB): The incidence of an early pregnancy (prior to 12 weeks) miscarriage is common and is estimated to effect 15-20% of all pregnancies. Regardless of the gestation period, many women will form an early attachment to their baby, therefore, regardless of the period of gestation, they are likely to go through a period of mourning. This particular study explored the emotional experience, grief and depressive symptoms in women and men, at one week and again at 4 months after their miscarriage. Findings from this particular study demonstrate that the loss of a pregnancy can lead to immediate and long-term feelings of grief, depression and guilt for both women and men. Although, the emotional feelings of grief and depression were more pronounced for the women than their male partners at 4 months. Women without children experienced higher scores for isolation and guilt and, as expected, women who had experienced a previous miscarriage had scored a higher score in all three factors; emotional experience, grief and depressive symptoms. At 4 months, the measurements of grief demonstrated a significant difference between men and women, the active grief and difficulties of coping were reduced when compared for one week, but the feelings of despair remained the same. The outcomes of this study confirm the findings of previous studies in this area, that miscarriage is a shattering and emotional experience for women and their partners. Women without children, and those who had experienced a previous miscarriage or undergone infertility treatment showed significantly more grief than those women who had previous children.

Reference: Midwifery 2018;64:23-8

Reviewing the effect of hyperemesis gravidarum on women’s lives and mental health

Authors: Dean K et al.

Summary: This literature review of nausea, vomiting and hyperemesis gravidarum in pregnancy was conducted to examine the relationship between hyperemesis gravidarum and psychological morbidity. In relation to mental health effects, four themes emerged: (1) social isolation; (2) inability to care for self and others or change of role; (3) negative psychological effects including depression, anxiety, guilt and loss of self; (4) sense of dying, suicidal ideation or termination. Two further subthemes were also identified: (a) loss of earnings or employment; (b) and changes to family plans. A holistic biopsychosocial approach to care is required, with health professionals allowing women to express feelings and providing validation, and providing perinatal mental health team referral or a peer support system as necessary.

Comment (KB): This well conducted review of the literature reports on women’s experience of hyperemesis gravidarum. The paper provides us with a summary of the effects this debilitating condition has on many women’s lives. Understanding the impact it has on women enables those providing care to tailor psychosocial care more appropriately. The authors conclude that women would benefit from a more holistic integrated approach to care, where women have their experience not just heard but validated. Case load midwifery should be the norm for all women as it provides the holistic recommended by the authors of this paper.

Reference: BJM. 2018;262(2):109-19

Comment (KB): The substantivity of the relationship between hyperemesis gravidarum and psychological morbidity. In relation to mental health effects, four themes emerged: (1) social isolation; (2) inability to care for self and others or change of role; (3) negative psychological effects including depression, anxiety, guilt and loss of self; (4) sense of dying, suicidal ideation or termination. Two further subthemes were also identified: (a) loss of earnings or employment; (b) and changes to family plans. A holistic biopsychosocial approach to care is required, with health professionals allowing women to express feelings and providing validation, and providing perinatal mental health team referral or a peer support system as necessary.

Reference: BJM. 2018;262(2):109-19

Abstract
Pregnancy nutrition knowledge and experiences of pregnant women and antenatal care clinicians: A mixed methods approach

Authors: Lee A et al.

Summary: This explanatory sequential research mixed methods study was conducted in Melbourne to examine pregnancy nutrition knowledge and explore how this knowledge affects food choices in pregnant women and nutrition education practices among antenatal care providers. A healthy diet is an important part of a healthy lifestyle at any time, but it is especially vital during pregnancy. Inadequate diets can lead to nutrient deficiencies, which are associated with pre-term birth, and birth defects. Improving the nutrition knowledge of pregnant women could be a cost-effective approach to improve the outcomes for both mother and the baby. The results from this study suggest the majority of women were well aware of the requirement of folic acid and the need to refrain from alcohol, and that certain cold meats and feta cheese were risk foods for listeria. However, they had limited knowledge about the energy requirements of women and weight gain recommendations for pregnant women. Women indicated that they relied mostly on the GP, obstetricians and midwives for nutritional advice, although only 33% of women surveyed indicated that they had received any nutrition advice from a clinician at any time during their pregnancy. The majority of participants reported using the internet, social supports, and books as well as health professionals to source nutritional information. Conversely, clinicians reported relying on alternative sources of information such as undergraduate training, colleagues, professional organisations, academic journals and personal experience. Clinicians suggested they were motivated to provide nutritional information to women because they believed this was best practice and they had a sense of professional responsibility to women. Pregnancy provides an opportunity to provide women with nutritional advice that could enhance and improve diet; however, the results of this study demonstrated that the nutrition advice provided was variable, which could be explained by the low-to-moderate nutrition scores attained by the clinicians, highlighting a gap in their knowledge base in this area. This suggests that there is a need to develop targeted nutrition programs for qualified clinicians as well as enhancing nutrition information in education programs in both undergraduate and postgraduate education programs.

Comment (KB): This explanatory sequential study was utilised to assess and compare pregnancy nutrition knowledge impacts on food choices in pregnant women and nutrition education practices among antenatal care providers. A healthy diet is an important part of a healthy lifestyle at any time, but it is especially vital during pregnancy. Inadequate diets can lead to nutrient deficiencies, which are associated with pre-term birth, and birth defects. Improving the nutrition knowledge of pregnant women could be a cost-effective approach to improve the outcomes for both mother and the baby. The results from this study suggest the majority of women were well aware of the requirement of folic acid and the need to refrain from alcohol, and that certain cold meats and feta cheese were risk foods for listeria. However, they had limited knowledge about the energy requirements of women and weight gain recommendations for pregnant women. Women indicated that they relied mostly on the GP, obstetricians and midwives for nutritional advice, although only 33% of women surveyed indicated that they had received any nutrition advice from a clinician at any time during their pregnancy. The majority of participants reported using the internet, social supports, and books as well as health professionals to source nutritional information. Conversely, clinicians reported relying on alternative sources of information such as undergraduate training, colleagues, professional organisations, academic journals and personal experience. Clinicians suggested they were motivated to provide nutritional information to women because they believed this was best practice and they had a sense of professional responsibility to women. Pregnancy provides an opportunity to provide women with nutritional advice that could enhance and improve diet; however, the results of this study demonstrated that the nutrition advice provided was variable, which could be explained by the low-to-moderate nutrition scores attained by the clinicians, highlighting a gap in their knowledge base in this area. This suggests that there is a need to develop targeted nutrition programs for qualified clinicians as well as enhancing nutrition information in education programs in both undergraduate and postgraduate education programs.

Reference: Women Birth 2018;31(4):269-77

Abstract