



## Midwives' perception of their role in providing antenatal asthma management in Australia – A qualitative study



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### ABSTRACT

International guidelines recommend a collaborative approach to the care of pregnant women with asthma. Midwives, as the primary health care provider for childbearing women should be viewed as collaborative partners in the provision of antenatal asthma management. However, the role of the midwife in providing antenatal asthma management has not been widely reported.

**Method:** Australian midwives' perceived role in antenatal asthma management was studied using a qualitative descriptive method. Semi-structured in-depth interviews were conducted with 13 midwives working in a regional tertiary hospital. Morse and Field's four-stage process was used to analyse the data. **Findings:** the perceived role of the midwife in antenatal asthma management varied among participants. Some midwives stated their role was to refer women on to other health professionals. Other midwives stated that they should provide education to the women regarding their asthma management during their pregnancy.

**Conclusion:** participants were uncertain about their role and lacked confidence in antenatal asthma management. The midwifery context in which they worked and the resources available to them at this health care facility appeared to influence the perception of their role.

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### Introduction

In Australia the midwife is defined as a health professional who, 'works in partnership with women and their families to give the necessary support, care and advice during pregnancy' (Australian College of Midwives, 2004, p. 1). Scientific evidence, experience and intuition form the basis of midwifery practice and collaboration and consultation with other health professionals is considered to be part of the midwife's role.

The World Health Report released in 2008 by the World Health Organisation (WHO) emphasised the need for health systems reform to be based on a primary health care approach (WHO, 2008). In the Australian Nursing and Midwifery Accreditation

Council's (2010a, 2010b) National Competency Standards for the Midwife, there is an emphasis on primary health care and consequently it is necessary for the midwifery profession to view itself as a public health strategy and resource. Bradley (2010) states that midwives are well placed to influence the health and well-being of women and children and should therefore see their role in the context of public health in the UK. Biro (2011) also states that midwives regularly provide public health interventions and health promotion messages to pregnant women. Johnson (2007) reports that midwives in the UK are aware of the need for further public health screening and attention to particular social problems, but identify barriers such as the lack of time and resources available to midwives in order for them to effectively address these issues.

The extension and enhancement of the provision of primary care by midwives in Australia is being examined due to research reporting that women are requesting more choices in primary care and this includes continuity of carer and an individualised approach to care (Lumley, 2000). There is also evidence that midwifery-led continuity of care models are cost effective and safe

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options for women of any risk during pregnancy (Sandall et al., 2013). Advanced practice levels in the midwifery workforce that allow midwives to work autonomously, and critical workforce shortages which demand the efficient utilisation of skilled maternity care providers whilst matching the needs of the women and families requiring antenatal care, are also leading to an expansion of the midwife's role (Australian Health Ministers' Advisory Council, 2008).

The public health issue of asthma in pregnancy has not previously been addressed in regard to the role of the midwife. Asthma continues to be one of the most common potentially serious conditions that complicates pregnancy with approximately 12.7% of pregnant women in Australia affected by it (Sawicki et al., 2011). Literature demonstrates that if asthma is well managed throughout pregnancy, adverse maternal and foetal outcomes such as maternal hypertension, pre-term birth and low infant birth weight can be reduced (Schatz, 1995; Murphy et al., 2006, 2011). The clinical course of asthma during pregnancy is unpredictable, making management challenging (Kircher et al., 2002). The goal of effective asthma management during pregnancy is the prevention of exacerbations, which can cause hypoxic episodes in the mother and reduce oxygen to the fetus.

The recommended management of asthma during pregnancy is outlined in the guidelines developed by the National Asthma Education and Prevention Program [NAEPP] (National Heart Lung and Blood Institute, 2007). National Asthma Council Australia [NAC] (2014) has also produced evidence-based guidelines addressing antenatal asthma management. These guidelines recommend a holistic and collaborative approach to management, suggesting cooperation between all health professionals involved in the pregnant woman's care. Women with asthma should be offered regular asthma review every 4–6 weeks. Pharmacological treatment of asthma should be the same as treatment for the non-pregnant woman. Women should be educated to minimise exposure to their asthma triggers and seek prompt management of exacerbations during pregnancy (National Heart Lung and Blood Institute, 2007; NAC, 2014).

Recently, Lim et al. (2014) evaluated a multidisciplinary approach to the management of maternal asthma in Australia, focusing on management by general practitioners (GPs), pharmacists and asthma educators. Midwives were not included in this study. Other public health issues have been examined in relation to midwives' provision of antenatal management, including provision of listeria education (Bondarianzadeh et al., 2011) and oral health education (George et al., 2011). The perceived role of the midwife in relation to these health issues varied between midwives with some stating their role was to educate women regarding the health issue and others who felt their role was to refer women to other health professionals.

## Aim

Effective antenatal asthma management is important for both the mother and infant, and yet there is limited research addressing antenatal asthma management by midwives. The aim of this study was to examine midwives' perceived role in antenatal asthma management. Data relating to the barriers facing midwives in relation to antenatal asthma management have been reported in a separate paper (McLaughlin et al., 2015).

## Method

A qualitative descriptive study design was used. The study was conducted in the antenatal clinic of a large tertiary referral public

hospital in regional NSW, Australia. The antenatal clinic is managed by a midwifery unit manager and a midwifery team leader who co-ordinate the various clinics on a daily basis. Approximately 50 women per day are provided care in the antenatal clinic at the hospital where this study was conducted. Many more are seen in community outreach clinics, which are available to women who live some distance from the facility and require antenatal care in their community. Various midwifery and obstetric models of care are co-ordinated from this clinic setting.

A purposive maximum variation sampling technique was used in order to recruit midwives in the clinical setting. The use of this sampling technique allowed the recruitment of midwives engaged in antenatal care provision from various models of practice. Data were collected through a series of individual semi-structured interviews. The interview schedule was developed using expert clinician advice and a peer review process. These interviews occurred in 2012 over a six month period. Data were collected from a total of 13 consenting participant midwives. During the interviews the researcher also documented field notes. Interviews were digitally recorded and subsequently transcribed and de-identified using participant identification numbers. Member-checking occurred when the interview transcripts were returned to the participants to confirm their accuracy.

The data analysis process described by Morse and Field (1996) was used. This process allows the researcher to become immersed in the data and continually work through four stages in order to maximise understanding of the data. The stages of this process include: *Comprehending* or 'making sense' of the data, *Synthesising* or further exploring the data in order to identify recurrent words and comments, *Theorising*, whereby the relationships between the words and comments are identified and categories and sub-categories are emergent from the data, and *Recontextualising*, which further develops the emergent categories and sub-categories and considers these in relation to the established knowledge of the topic. A more detailed description of this data analysis process is reported in the previous publication discussing barriers that midwives face in relation to antenatal asthma management (McLaughlin et al., 2015).

To ensure rigour a well-established research method was used and an audit trail was documented. Potential transferability was enhanced by the provision of a rich description of the study setting. To demonstrate that the research findings are grounded in the data, quotes from the interviews are used. Analyses of these data were also peer reviewed by qualitative experts.

The Hunter New England Area Health Service Human Research Ethics Committee (HREC) and the University of Newcastle HREC granted ethical approval for this study.

## Findings

The midwives participating in the study had varying years of experience and models of midwifery care in which they practiced (Table 1).

Analysis of the data led to the establishment of categories and sub-categories in which there were four main categories and 12 sub-categories (Fig. 1).

A main category was the perceived role of the midwife in antenatal asthma management. The sub-categories identified were *Midwives' role as educator in asthma management* and *Midwives' role as referrer of pregnant women with asthma to other health professionals*. Additional findings will be discussed in other papers.

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