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Factors influencing the implementation of advanced midwife practitioners in healthcare settings: A qualitative study

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ABSTRACT

Objective: To explore factors influencing the implementation of advanced midwife practitioner roles.
Design: Semi-structured individual face-to-face and focus group interviews were conducted. Data analysis was performed using the Framework Method.
Setting and participants: A purposive sample ($n = 32$) included chief nursing officers, middle managers, head midwives/nurses, primary care team leaders, midwives with and without advanced midwife practitioner roles, heads of midwifery educations, and obstetricians.
Findings: Budgetary constraints on a governmental and healthcare organizational level were mentioned as main barriers for role implementation. The current fee-for-service financing model of healthcare professionals was also seen as an impediment. Obstetricians considered the implementation of advanced midwife practitioner roles as a possible financial and professional threat. Documenting the added value of advanced midwife practitioner roles was regarded a prerequisite for gaining support to implement such roles. Healthcare managers' and midwives' attitudes towards these roles were considered essential. Participants warned against automatically transferring the concept of advanced practice nursing to midwifery. Although participants seldom discussed population healthcare needs as a driver for implementation, healthcare organizations' heightened focus on quality improvement and client safety was seen as an opportunity for implementation. University hospitals were perceived as pioneers regarding advanced midwife practitioner roles.
Key conclusions and implications for practice: Multiple factors influencing role implementation on a governmental, healthcare organizational, and workforce level illustrate the complexity of the implementation process, and highlight the need for a well-thought-out implementation plan involving all relevant stakeholders. Pilot projects for the implementation of advanced midwife practitioners in university hospitals might be useful.

Introduction

In several healthcare disciplines, advanced practice is distinguished from basic practice through specialization and expansion of knowledge, skills, and role autonomy (Bryant-Lukosius et al., 2004; Steer et al., 2015). In midwifery, advanced practice is described as "*a level of midwifery practice at which midwives use their expertise, management and clinical leadership skills to provide evidence-based, tailored care for women and their families independently and autonomously. Professional leadership and research skills are used to evaluate practice and advance midwifery as a profession and science*" (Goemaes et al., 2016). Several titles are used internationally for referring to midwives with minimum a master's degree

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taking on the following roles besides the role of expert clinical practitioner: clinical and professional leader, educator, researcher, policy advisor, innovator, consultant or facilitator of ethical decision making (Lesia and Roets, 2013; Elliott et al., 2014; Walker et al., 2014). Such titles are (advanced) midwife practitioners, advanced (practice) midwives, and consultant midwives. In this paper, all midwives practicing on an advanced level as described above will be referred to as advanced midwife practitioners (AMPs).

Advanced midwife practitioners are seen as new roles in healthcare and considered essential for high quality healthcare and the development of the profession (Begley et al., 2007). Several studies reporting on clinical outcomes support the desirability of implementation of advanced practitioners in healthcare settings (Begley et al., 2010; Newhouse et al., 2011; American College of Nurse Midwives, 2012; Weitz et al., 2013; Patil et al., 2016; Casey et al., 2017a). Despite limited evidence that supports the contribution to professional (e.g. education of staff) and organizational outcomes (e.g. quality of care, cost and access to services) that can be attributed uniquely to advanced practitioners (Begley et al., 2014; Casey et al., 2017a), Casey et al. (2017b) concluded that the potential positive impact of such roles cannot be doubted (Casey et al., 2017b). In addition, midwives are increasingly confronted with complex care situations as the number of women with pregnancy complications and high risk pregnancies due to pre-existing health conditions are growing (Centers for Disease Control and Prevention, 2015; Qin et al., 2016). Furthermore, advanced midwifery practice could provide midwives with the possibility of a clinical career 'at the bedside', in which direct client care is combined with academic and leadership skills. This could prevent midwives educated at master's level from having to choose between client care and building a career in management, research or educational positions (De Geest et al., 2008).

A limited number of countries have implemented AMP roles (e.g. Ireland, the United Kingdom), despite the elements supporting the desirability of such roles (Department of Health and Social Care, 1999; Begley et al., 2007; National Council for the Professional Development of Nursing and Midwifery, 2008; Robinson, 2012). Furthermore, there is little international literature that discusses implementation processes of AMP roles. Data on the feasibility, barriers and facilitators for the implementation of AMP roles are lacking internationally. These data are also lacking for Belgian healthcare settings, notwithstanding elements that support a discussion on the implementation of AMP roles. Firstly, the extension of legal competences of Belgian midwives since 2006 (e.g. prescription authority) has intensified a discussion on the duration and level of midwifery education in Belgium (Federal Council for Midwives, 2016). This education consists of a three-year direct-entry midwifery programme equivalent to 180 ECTS and leads to a professional bachelor's degree in Flanders. In the Walloon region, the education consists of a four-year bachelor programme equivalent to 240 ECTS, in which students spend one year on nursing, one year on nursing and midwifery, and two years on midwifery (Emons and Luiten, 2001). Secondly, there is a lack of formally acknowledged discipline specific clinical positions in which master educated midwives can structurally contribute to care innovation, quality improvement and evidence-based practice.

Literature from related healthcare disciplines shows that implementation of advanced practitioner roles is complex. Several frameworks for the development, implementation and evaluation of advanced practice nursing roles have been developed (Bryant-Lukosius et al., 2004; Furlong and Smith, 2005; De Geest et al., 2008). These frameworks recommend the need for a new model of care involving advanced practitioner roles and the identification of role barriers and facilitators as two vital steps in the implementation process (Bryant-Lukosius et al., 2004; Furlong and Smith, 2005; De Geest et al., 2008). As the implementation of AMP roles is still in its infancy in Belgium, therefore, this study aimed to explore the factors influencing the implementation of AMP roles in Flanders, the Dutch-speaking part of Belgium. This will enhance the limited knowledge on AMP role implementation internationally.

Methods

Design

A qualitative study was undertaken using the Framework Method (Gale et al., 2013). Both individual and focus group interviews were held.

Sample

Key stakeholders from Flanders were invited to participate. Participants were selected based on their expertise in (1) the domain of advanced and specialist midwifery practice, (2) healthcare management on an operational or strategic level, (3) midwifery education, (4) healthcare policy, or (5) a medical specialty related to midwifery care domains (e.g. obstetrics and gynecology). Professionals from a variety of healthcare settings, professions, positions, and experience of working with midwives with an AMP profile were selected using purposive sampling. The characteristics of the participants are reported in Table 1.

Participants working in a hospital setting were informed about the study and personally invited to partake by email with permission of or via the chief nursing officers (CNOs). The latter were contacted directly by email. Clinicians working outside of the hospital setting were informed about the study by email and electronic newsletters via their professional associations after consent of the professional organizations' Board of Directors.

Data collection

Both individual and focus group interviews were conducted. As the implementation of advanced practice roles is seen as complex, within-method triangulation is regarded beneficial for collecting data on a complex theme (Wadsworth, 2000). A combined data collection strategy allows for the comparison of data collected in individual and focus group interviews, which enhances trustworthiness of the findings (Lambert and Loiselle, 2008). In addition, the dynamic interaction between participants during focus group interviews stimulates their thoughts as well as debate about the topic and contributes to generating rich data (Holloway and Galvin, 2017). Furthermore, the combined use of individual and focus group interviews facilitates a maximum range of perspectives that can be included within the boundaries of available resources, potentially contributing to a greater depth and breadth of data and "a more nuanced understanding" (Wadsworth, 2000; Lambert and Loiselle, 2008).

Individual semi-structured face-to-face interviews were conducted between January 2016 and February 2017. Twenty-two participants were interviewed at a date, time and location of their choice. Each individual interview lasted between 31 and 89 min (average duration 61.4 min). Two focus group interviews were conducted between July and August 2016. The focus groups consisted of three and seven participants, respectively. The focus groups took place at a date, time and location that was most convenient for a maximum number of participants. The focus groups lasted between 64 and 109 min (average duration 86.5 min).

Purposive sampling was used to broaden initial insights and to include participants with and without familiarity with AMP roles, and participants from both university and peripheral hospitals. The latter was done as university and peripheral hospitals provide different contexts for care provision. Besides providing the care of peripheral hospitals, the mission statement of university hospitals includes the provision of expert care in complex care situations, care innovation and development, clinical training for (medical) students and specialists, and research (Royal Decree of 7 June, 2004).

New participants were selected until data saturation was reached, which occurred after the analysis of 20 individual and two focus group

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