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Midwives' beliefs and concerns about telephone conversations with women in early labour

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ABSTRACT

Objective: to explore midwives' concerns, experiences and perceptions of the purpose of telephone contacts with women in early labour.
Design: a qualitative design based on interpretive phenomenology.
Setting: two Maternity Units in the Midlands of England.
Participants: three focus groups of labour ward midwife co-ordinators and labour ward midwives and nine in-depth interviews of midwives, obstetricians and labour ward receptionists.
Findings: the principal finding was that midwives are trying to reconcile gatekeeping of labour wards with individual support for women and these two aspects are often in conflict. Women experiencing prolonged or painful early labour often expect to be admitted to labour wards whereas midwives operate from a belief that women should only be accepted onto labour ward in active labour. They hold this view because labour wards are busy places and being admitted early contributes to unnecessary medical intervention.
Key conclusions: because midwives are trying to reconcile the two conflicting priorities of responding to women's needs and protecting the labour ward from inappropriate admissions, the potential always exists for women's needs to be 'not heard' or marginalised.
Implications for practice: the primary recommendation is that early labour telephone triage should be a discrete service, staffed by midwives who have been trained for this service, working independently of labour ward workloads.

Introduction

Early labour care has been a problem for childbirth professionals and women over the past 20 years (Janssen et al., 2009). The majority of women are managed through telephone advice initially and then assessment either on labour wards or separate assessment centres (McNiven et al., 1998; Hodnett et al., 2008). Both of these settings operate on the premise that hospital labour wards are not an appropriate place for women in early labour because research has shown that women have more labour interventions if admitted there (Bailit et al., 2005; Rahnama et al., 2006). This probably happens because labour ward staff eventually recommend speeding up labour by undertaking artificial rupture of membranes and administering an oxytocin infusion. Accelerating labour in this way may be linked to organisational pressures, rather than clinical need as there is a widely held belief that a long latent phase of labour does not necessarily predict complications in later labour (El-Hamamy and Arulkumaran, 2005). Therefore, it follows that women should only be cared for

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on labour wards when they are in the active phase of the first stage of labour. This conclusion is endorsed by most midwives and obstetricians. However, there is an alternative body of research that has explored women's perceptions of their early labour care and tends to arrive at a different conclusion (Barnett et al., 2008; Eri et al., 2010; Nyman et al., 2011).

This research demonstrates that many women need either ongoing support during the latent phase of labour (Eri et al., 2010) or believe they are in active labour when the professionals say they are not (Gross et al., 2003). Maternity services are generally not well equipped to provide early labour support so either these women are asked to remain at home after receiving telephone advice or are sent home after an initial hospital assessment.

There is a small body of research which has specifically examined women's views of telephone communications in early labour (Nolan and Smith, 2010; Green et al., 2012), concluding in the main that many were dissatisfied and had unmet needs for advice and support. Effective communication requires congruence between the needs and expectations of users and providers of maternity care and that cannot be achieved until midwives' perspectives are more clearly understood. As yet, prior research has not specifically addressed this aspect.

For midwives, telephone conversations take place in the context of a busy clinical area, where the needs of women telephoning the maternity unit have to be balanced with responsibilities for those already admitted (Webb, 2004). Because women who are admitted in early labour and stay on labour wards tend to have more labour interventions, one way of addressing this is by encouraging later admission in labour. Midwives play a key role as gate-keepers to the labour suite. Their decision-making has implications for women's choice of pain relief methods, psychosocial outcomes, clinical safety (including unattended births or babies born before arrival) and perceptions of service quality. Midwives who participated in focus groups about their experiences of the telephone component of the All Wales Pathway for Normal Labour and Birth questioned the appropriateness of telephone assessment (compared to face-to-face) and expressed concerns about potential complaints (Green et al., 2012).

It is clear that there is a need to explore specifically midwives' views of telephone conversations around early labour to inform maternity service re-design, midwifery education and practice.

The research aims are:

- To explore midwives' concerns, experiences and perceptions of the purpose of telephone contacts with women in early labour.
- To explore the characteristics of satisfactory and unsatisfactory telephone conversations with women in early labour from the midwives' perspective.

Methods

A qualitative design based on interpretive phenomenology was utilised as the most appropriate approach to evaluate perceptions and experiences. This branch of phenomenology derives from Heidegger who posited that an individual's 'life world' was shaped by the context in which she/he lives and that experience is always filtered through an interpretive lens. It is never pre-reflexive (Thomson et al., 2011). This is appropriate for examining midwives' views of the phenomenon of telephone calls from women in early labour. The method acknowledges that midwives interpret these calls from their embedded position of practising in a large maternity hospital.

The setting was one NHS Trust in England where maternity care is provided on two sites: Site 1 with 4000 births/year and Site 2 with 5000 births/year with mixed risk caseloads. Both sites serve a predominantly urban area and provide care for women and families from a wide range of ethnicities and backgrounds.

Ethics approval was granted by the University Research Committee and research governance approval by the host NHS Trust; sponsorship was provided by the University.

Data were collected via three focus group discussions, two conducted with four labour suite co-ordinators from each of the hospitals. The third focus group consisted of six labour ward midwives, three from each site and included midwives with a mix of clinical experience including those within their first year of qualification and those with more experience. In addition, nine semi-structured interviews were carried out with key informants: midwifery risk manager, two labour suite managers, two modern matrons, two obstetricians, one midwifery lecturer and a labour ward receptionist. The study included non-midwife participants to reflect the multidisciplinary provision of maternity services and contribution of other roles to service delivery. All focus groups and interviews were digitally recorded and fully transcribed. These were analysed using interpretative phenomenological analysis (Smith et al., 2009) by DW and HS. The following strategies were used: line by line analysis of concerns and understanding of participants; the identification of emergent themes by examining convergence and divergence of ideas; a dialogic process of moving between emergent themes, repeated rereading of texts and discussion with a second member of the team (HS) who reviewed all transcripts; the development of core themes. DW and HS discussed all identified codes and findings. These were circulated and discussed by all members of the research team.

Findings

The findings from the interviews and focus groups are presented as nine themes. These were organisational model, the telephone call, clinical parameters of assessment, labour ward busyness, education for women, training for midwives on telephone triage, advice for staying at home, successful calls, unsuccessful calls.

Organisational model

Though the two hospitals (Site 1 and Site 2) had the same written guidelines on early labour management and the two hospitals (Site 1 and Site 2) have similar operational models, there were differences regarding the day to day management of the telephone service. All of the interviews and focus groups referred to this. Both sites have an Assessment area separate from the labour ward but only the smaller of the two (Site 1) takes calls from women in early labour and that is only during daytime hours. This site does not invite women into the Assessment area to be seen and triaged, unlike most other UK maternity services, but directs them to labour ward. If they have invited a woman in, they notify the labour ward. Out of hours, the early labour calls go directly to the labour ward where any midwife in the vicinity answers the call. This has evolved because the co-ordinator at this site is often doing clinical care and is therefore not available to take the call.

At Site 2, all early labour calls are directed through to the labour ward where the co-ordinator in charge of the shift receives and deals with them. She is not usually involved in the continuous provision of direct care of women and is therefore freer to co-ordinate the workload. Their assessment area does not take any calls about early labour at term and only deals with women with complications and specific at-risk pregnancies.

Both sites have a recording sheet to note down individual women's details; these differ between sites. Site 1 has a proforma sheet with fairly comprehensive clinical details that is completed by the midwife taking the call. This is then retained and filed with

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