Midwifery 29 (2013) 277–283

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Early labour services: Changes, triggers, monitoring and evaluation

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ARTICLE INFO

Article history:
Received 9 August 2011
Received in revised form
1 May 2012
Accepted 11 May 2012

Keywords:
Early labour
Category X
Triage
Home assessment

ABSTRACT

Objectives: to identify the changes to early labour services, their triggers and monitoring.
Design and setting: a mixed methods approach in two stages, firstly a postal questionnaire survey of Heads of Midwifery (HoM) services in NHS Trusts in England (cover sheet to each HoM and questionnaire for each unit in their jurisdiction) and, secondly, semi-structured telephone interviews with a purposive sample of senior midwives. The interviews sought further information about reasons for change; the impact of changes and explored the unit's particular innovations.
Participants and response rate: 145 (89%) NHS Trusts provided data (cover sheet and/or questionnaire); responses were received from all areas and types of unit. Seventeen HoMs or designated senior midwives were interviewed.
Findings: 83 of 170 units (49%) had made changes to early labour service provision during the past 5 years, including home assessment; the introduction of triage units and telephone assessment tools. Changes were more likely in high volume units and in consultant units with midwifery-led care areas. Further changes were planned by 93/178 (25%) units. Triggers for changes to early labour services comprised local or unit-based factors, including Category X (non-labour) admissions, response to service users and research evidence. The impact of Category X admissions on workload contributed to the triggers for change. Fifty-six (31%) could provide a confirmed figure or estimate for category X admissions. Experiences of introducing change included issues related to engagement of the workforce and the contribution of clinical leadership. Thirty-eight (48%) units did not routinely monitor use of early labour services. Overall monitoring of services was not significantly more likely in units that had made changes. Audit activity was reported more frequently in units that had made changes to their early labour services.
Conclusions: early labour services had undergone significant changes following a range of triggers but the extent of change was not reflected in monitoring and evaluation activity.
Implications for practice: Changes to service provision should be accompanied by monitoring and evaluation. Changes to services require utilisation of appropriate change management strategies.
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Introduction and background

Early labour is an important component of women's overall clinical and psychosocial experiences of childbearing (Barnett et al., 2008; Hodnett et al., 2008; Nolan and Smith, 2010). This importance is receiving increased attention internationally (Green and Spiby, 2009). In the UK, since the late 1960s when labour and birth moved into hospitals, for the majority of women early labour assessment has taken place in maternity units. Thus early labour is a time of transition and travel to the maternity unit requiring decisions that affect a number of people. There can be uncertainty about *when* to travel to the maternity unit. Retrospective studies identified associations between admission to maternity units at lower cervical dilatation with increased likelihood of interventions during labour and birth (Hemminki and Sumukka, 1986; Holmes et al., 2001). Once in the maternity unit, a woman remains, isolated from her wider family and social network, in clinical *delivery* rooms rather than spending early labour in her own surroundings, with supportive friends. If found

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http://dx.doi.org/10.1016/j.midw.2012.05.007

not to be in labour, women may be asked to return home to re-attend when labour is further established; this can be both embarrassing and costly for the woman and her family. Exceptions to assessment in the maternity unit are associated with some models of midwifery working, for example, the Domiciliary In and Out (DOMINO) scheme and caseload midwifery where home assessment or telephone support may be provided by a midwife who already knows the woman.

Early in the new millennium, a number of new approaches to early labour service provision were reported in midwifery and health service journals. These include the creation of midwifery triage services, provided by phone or in areas away from the main labour ward and the All Wales Pathway for Normal Labour and Birth that aimed to provide an evidence-based template for labour care for low risk women. Triggers for these changes included the high proportion of women attending labour wards who were not in labour, with negative impacts on the care of women in established labour (Dennett and Baillie, 2002) and a desire to support normality in childbearing by delaying hospital admission (Ferguson, 2004). The organisation of early labour care has considerable implications for service providers in terms of staffing and other resource requirements (Dennett and Baillie, 2002; Cheyne et al., 2006). Whilst reported positively for their impacts in reducing activity on main labour wards, systematic evidence about different approaches to providing early labour services and triggers for changes to provision is, however, sparse.

In England, maternity care is provided by the National Health Service and free at the point-of-service, funded by taxation. NHS Trusts are organisations responsible for the provision of health services, including maternity care and employ health-care practitioners including midwives. Maternity care takes place in both primary and secondary care settings and intra-partum services may be provided in consultant obstetric units, midwifery led units/Birth Centres (Stand Alone or Alongside) and in the woman's own home. The organisation of services varies in different areas and Trusts may provide intrapartum care in one or more maternity units on different sites.

This study focuses on early labour services in England but provides information about changing early labour services that has relevance internationally. It was one component of a suite of mixed-methods research that examined service provision in England and Wales for women in early labour. The suite of studies was referred to as Options for Assessment in early Labour (OPAL). The specific objective addressed in this paper was to map early labour services in England and explore innovations.

Methods

A two-stage approach to data collection was designed; the first stage aimed to identify early labour services throughout England using a postal questionnaire survey of Heads of Midwifery (HoM) with a particular emphasis on innovation in early labour service provision. HoMs are midwives working at a senior managerial level whose role may include strategic leadership and operational responsibility for midwifery and maternity services. The second stage explored aspects of the introduction and discontinuation of particular approaches to early labour services using telephone interviews.

Stage 1: We conducted a pilot study to obtain feedback about the questionnaire's content and presentation from seven HoMs to ensure face validity and utility for respondents; minimal changes were required. Following piloting, a questionnaire was posted to the Head of Midwifery in every NHS Trust in England, to obtain information about each maternity unit in their jurisdiction. These units include Stand Alone Birth Centres and consultant led obstetric units with or without Midwifery Led Care areas. The sample was identified using three sources: contact with all Local Supervising Authority (LSA) Midwifery Officers; cross-reference with Binleys Online database; and searches of Trust websites and contact with their maternity departments.

Each HoM received a letter and information about the OPAL study, together with a one page proforma [referred to as the cover sheet] which sought to confirm details of the maternity unit(s) in their jurisdiction and the name of the person(s) – themselves or a designated deputy – who would complete the main questionnaire for each unit. The cover sheet also included a question specifically aimed at the HoM regarding the use of NHS Direct (a health advice and information service provided by the NHS in England and available at all times) in early labour (findings from this question are reported in a separate paper). For those responsible for more than one unit, individual labelled questionnaires were sent to the HoM for distribution to each unit. The questionnaire sought information about size and configuration of the maternity unit organisation of midwifery and early labour services; changes to early labour services and the associated impacts; information for women; guidance for professionals and monitoring of early labour services. Questionnaires included both closed response and open-ended questions.

In total, 163 cover sheets (one per HoM) and 241 questionnaires (one per maternity unit) were sent out, together with a letter introducing the research and study information sheet. Reminders were subsequently sent out using a range of methods and time points: email to HoM (3 weeks following initial distribution for non-return of cover sheets); postal (7 weeks for non-return of cover sheets and questionnaire with offer of email completion) with a final telephone reminder to non-responders to confirm receipt of documents, re-sending where necessary. The Royal College of Midwives supported the study and encouraged response in a general email to their HoMs' list.

Questionnaire data were entered into an SPSS database. Analysis of quantitative data included frequency, distribution and χ^2 tests of significance, where appropriate. For some questions, responses were combined to support statistical analysis. Free-text responses were analysed using simple content analysis to identify themes (Miles and Huberman, 1994).

Stage 2: Telephone interviews were carried out with a purposive sample of 17 HoMs or a designated senior midwife. Respondents were selected from those whose questionnaires reported the introduction of innovative services or a discontinued service. Examples of innovations included triage units, Birth Centres, Day Assessment Units, drop-ins, home assessment and telephone helpline. Semi-structured interview schedules were used to obtain further information about early labour services in that unit and their availability; the provision of information to women, the nature of and reasons for service change and the impact of the changes on workforce, resources, training and workload in those units. HoMs were also asked whether the organisation of care influenced the provision of early labour services. Additional questions explored the particular innovations reported in that unit's questionnaire. Interviews, of approximately 45 mins' duration, were tape recorded and fully transcribed.

Ethical considerations: Based on the advice of the Leeds West Ethics Committee, approval was not required as the investigation was considered service evaluation.

This paper focuses on changes to early labour service provision, the associated triggers, monitoring and evaluation. Separate papers will deal in depth with the experiences of specific services including home assessment in early labour, triage areas and structured telephone tools and views about the potential to use NHS Direct for early labour services.

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