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Exploring midwives' perception of confidence around facilitating water birth in Western Australia: A qualitative descriptive study

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ABSTRACT

Objective: the option of labouring and/or birthing immersed in warm water has become widely available throughout hospitals in the United Kingdom and Europe over the last two decades. The practice, which also occurs in New Zealand and interstate in Australia, has until recently only been available in Western Australia for women birthing at home with a small publically funded Community Midwifery Program. Despite its popularity and acceptance elsewhere, birth in water has only recently become an option for women attending some public health services in Western Australia. The Clinical Guidelines developed for the local context that support water birth require that the midwives be confident and competent to care for these women. The issue of competency can be addressed with relative ease by maternity care providers; however confidence is rather more difficult to teach, foster and attain. Clinical confidence is an integral element of clinical judgement and promotes patient safety and comfort. For this reason confident midwives are an essential requirement to support the option of water birth in Western Australia. The aim of this study was to capture midwives' perceptions of becoming and being confident in conducting water birth in addition to factors perceived to inhibit and facilitate the development of that confidence.
Design: a modified grounded theory methodology with thematic analysis.
Settings: four public maternity services offering the option of water birth in the Perth metropolitan area.
Participants: registered midwives employed at one of the four publicly funded maternity services that offered the option of water birth between June 2011 and June 2013. Sixteen midwives were interviewed on a one to one basis. An additional 10 midwives participated in a focus group interview.
Findings: three main categories emerged from the data analysis: *what came before the journey, becoming confident – the journey* and *staying confident*. Each contained between three and five subcategories. Together they depicted how midwives describe the journey to becoming confident to support women who have chosen the option to water birth and how they are able to retain that confidence once achieved.
Implications for practice: three key implications emerged from this study, the first was that students and graduate midwives could benefit from the opportunity to work in midwifery led maternity settings that support normal physiological child birth and that accessing such practical placements should be encouraged. Secondly, maternity services would benefit from learning opportunities directed specifically at experienced midwives addressing their particular requirements. Finally, midwives are the custodians of normal physiological birth, attendance at educational days with a focus on supporting this primary role should be mandatory, to inform midwives on current evidence found to support normal birth which includes options such as water birth.

Introduction

Attainment of clinical competence is an integral requirement for safe midwifery practice. The Australian Nursing and Midwifery Council

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(ANMC) definition of competence outlined the multifaceted nature of the concept, clarifying that clinical competence reflects 'the combination of skills, knowledge, attitude, values and abilities that underpin effective and/or superior performance in a profession/occupational area' (ANMC, 2006, p. 3). On the other hand, confidence has been defined as 'a feeling of self-assurance from an appreciation of one's abilities' (Oxford Dictionaries, 2014 accessed online 28/01/14) and can have an impact on everything from psychological states to behaviour and motivation. It has been suggested that within healthcare low professional self-confidence can contribute to patients feeling uncomfortable (White, 2009; Perry, 2011). Confidence is, however, more important than a practitioner's capacity to ensuring patient comfort; clinical reasoning is influenced by confidence and the care provider's willingness to make a decision.

Ulrich and associates (2010) linked the concepts of competence and confidence, claiming that competence without self-confidence may be inadequate. Competence and confidence do not always co-exist though; one may be confident but not be able to demonstrate appropriate clinical competence. At the same time, a midwife can demonstrate competence in the performance of a particular skill but may not necessarily feel confident about it. Supporting women who wish to use immersion in warm water during labour and/or birth, which is increasing in popularity and availability, is one such skill that midwives may or may not feel competent and/or confident to facilitate.

In 2009 clinical guidelines for water birth were developed by the Western Australian Women's and Newborns' Health Network (WNHN) in response to increasing consumer demand for this option. The aim of these guidelines was to enable midwives to provide care that is as safe as possible for healthy pregnant women choosing a water birth whilst requiring the midwife to be **both confident and competent** to facilitate a woman's labour and/or birth in water (Department of Health Western Australia, 2009). The context around options for water birth in the metropolitan public maternity services in Western Australian (WA) differs from others internationally in that the option of birthing a baby underwater was not common prior the introduction of these clinical guidelines. In fact, the option of water birth prior to 2009 was only available in a home birth setting and supported either by the publically funded Community Midwifery Program or by midwives in private practice.

The requirement to be a confident water birth practitioner is not unique to WA. Operational statements, policies, guidelines and professional codes of conduct from bodies governing maternity care and practice throughout the United Kingdom (UK), New Zealand and Australia require that midwives supporting women choosing water birth be confident to support women with this birth option (RCM, 1994; Government of South Australia, 2005; RCOG., 2006; Women's and Children's Health, 2006; RANZCOG., 2008; Department of Health Western Australia, 2009), however no advice or insight is offered in any of these documents about how midwives should develop the confidence required to support women who had chosen the option of water birth.

Health professionals can be biased in their provision of information in that they may support one option over another without disclosing their preference (Masse and Legare, 2001). A lack of confidence on the part of the midwife may influence a form of protective steering that guides the labouring women back into the birthing room and the midwives' comfort zone, thus denying the woman the birth option she most desired for reasons that may be nothing to do with her own or her baby's well-being. A competent and confident work force is an essential element in providing options such as water birth for women. Therefore, this study explored the perception of professional confidence from midwives supporting water birth in WA public maternity services. The aim was to capture midwives' perceptions of becoming and being confident in conducting water birth in addition to factors perceived to inhibit and facilitate the development of that confidence.

Methods

Design

A modified grounded theory methodology was selected to address the phenomenon around the process of WA midwives developing confidence with water birth. Gaining understanding of the processes of clinical practice around professional development is well suited to using a grounded theory approach (Skeat, 2010). Approval was granted by the Curtin University Human Research Ethics Committee (approval number SONM1-2011) and the Human Research Ethics Committees of all the maternity services from which participants were recruited.

Sampling and recruitment

The sample for this study comprised midwives registered in WA and working in four Public Health maternity services offering the option of water birth. Data were collected between June 2011 and June 2013. Midwives who were both deemed competent by their employer to care for women who had chosen this option and perceived themselves as confident to do so were recruited.

Information sessions presenting an overview of the research were held during staff meetings at four maternity services and a water birth study day. Participants were asked to complete a demographic questionnaire that contained an item around confidence to facilitate water birth based upon a Likert scale numbered 1–10. This item was to inform sampling as the study progressed, ensuring midwives with a range of confidence levels were interviewed. In total 30 demographic questionnaires were returned from the participants that attended information sessions and the study day. Snowball sampling also resulted in a further 10 midwives being recruited from the four maternity settings (Schneider et al., 2013).

Initially, purposive sampling was employed whereby two midwives from each of the four maternity services were selected for the first eight interviews. As data collection and analysis progressed several categories relating to midwives confidence were identified so theoretical sampling was then used. Participants were selected from the demographic questionnaires based on characteristics to verify and expand upon emerging categories. For example, many midwives had gained their water birth confidence in the United Kingdom and were included in the initial sampling. Subsequently, more midwives who had been educated and worked in WA were included. Midwives who had completed the water birth competency requirements of their employer but who did not feel completely confident to facilitate water birth without supervision were also selected from the demographic questionnaires as theoretical sampling progressed.

Midwives were also recruited for a focus group which occurred once preliminary findings were available and provided an opportunity for member checking (Schneider et al., 2013). The focus group was around the phenomenon of building confidence to support the option of water birth and once the discussion was complete the preliminary categories and sub categories were introduced for further discussion to determine agreement around the preliminary analysis.

Data collection

Data were collected through in-depth one-to-one interviews which were audio recorded and transcribed verbatim. Interviews were carried out by the researcher at a time and location