



## Standards for midwife practitioners of external cephalic version: A Delphi study



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### ABSTRACT

**Introduction:** expansion of advanced and specialist midwifery practitioner roles across professional boundaries requires an evidence-based framework to evaluate achievement and maintenance of competency. In order to develop the role of Breech Specialist Midwife to include the autonomous performance of external cephalic version within one hospital, guidance was required on standards of training and skill development, particularly in the use of ultrasound.

**Methods:** a three-round Delphi survey was used to determine consensus among an expert panel, including highly experienced obstetric and midwife practitioners, as well as sonographers. The first round used mostly open-ended questions to gather data, from which statements were formed and returned to the panel for evaluation in subsequent rounds.

**Findings:** standards for achieving and maintaining competence to perform ECV, and in the use of basic third trimester ultrasound as part of this practice, should be the same for midwives and doctors. The maintenance of proficiency requires regular practice.

**Conclusions:** midwives can appropriately expand their sphere of practice to include ECV and basic third trimester ultrasound, according to internal guidelines, following the completion of a competency-based training programme roughly equivalent to those used to guide obstetric training. Ideally, ECV services should be offered in organised clinics where individual practitioners in either profession are able to perform approximately 30 or more ECVs per year in order to maintain an appropriate level of skill.

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### Introduction

Breech presentation at term has an incidence rate of 3–4% and is associated with an increased risk of caesarean section childbirth (RCOG, 2006). External cephalic version (ECV), the practice of manually turning the fetus from head-up to head-down in the

uterus, lowers this risk, especially where the option of vaginal breech birth is not supported (Hofmeyr and Kulier, 2012). In most hospitals in the United Kingdom (UK), ECV is performed by an obstetrician, but it may also be offered by a specially trained midwife (RCOG, 2006), a service delivery design which has been highly successful in some areas (Taylor and Robson, 2003).

This study aimed to determine an expert consensus on standards for competency, training and maintenance of skills for ECV practitioners, using the Delphi survey technique. The project arose while the main author was working in a moderate-sized (2200 births per annum) UK National Health Service (NHS) Hospital in England as the midwife facilitator of an innovative collaborative care pathway for women with breech-presenting babies. A basic skills set was identified, including sound knowledge of the

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evidence base concerning breech presentation, an understanding of the alternative options available, and an ability to communicate in a way that enables women to be a part of a decision making process that ensures informed choice is taking place. Additional clinical skills were targeted for development, including the assessment of presentation using ultrasound, external cephalic version and skills in facilitating vaginal breech birth.

Within this care pathway, a need for improvement of the ECV service was identified and prioritised. However, no obstetric lead was identified to support this initiative. Consequently, it was proposed that a role of Breech Specialist Midwife would be developed to incorporate the autonomous performance of ECV. Prior innovators have described the development of such a role for midwives and reported safety and success rates similar to those for experienced obstetricians (Burr et al., 2001; Taylor and Robson, 2003; McCormick and Cairns, 2010). However, no precedent for such a role expansion existed in the host institution. Therefore, further specific guidance on training standards was required, particularly in relation to assessing presentation using ultrasound, in line with other models of midwifery role expansion (UK National Screening Committee, 2008; Marshall, 2010). After discussion with the obstetric leadership, it was felt that the expertise available within the hospital was not adequate to establish a training programme without additional input from more experienced practitioners. The Delphi survey technique was identified as an appropriate method to help guide the innovation. The research was funded by the Innovation in Nursing and Midwifery Practice Programme (INMPP) (Crozier et al., 2012), which allocates small research grants to support research and innovation among front-line clinical staff.

### Purpose

The purpose of this study was to obtain a consensus among UK ECV experts on (1) core competencies for practitioners of external cephalic version, (2) the type of training appropriate for non-sonographer practitioners using ultrasound to diagnose breech presentation, and (3) the training and on-going requirements for practitioners to competently perform ECV and maintain proficiency in this procedure.

### Methods

A three round Delphi e-survey design was used to obtain an expert panel's views on these topics. The Delphi survey method is a consensus-development technique, involving a quasi-anonymous panel of experts in a series of sequential questionnaires (known as 'rounds'), interspersed with controlled feedback. The methodology's key value rests on the assumption that group opinion is more valid than individual opinion (Keeney et al., 2010). It has been applied in many areas of midwifery, medical and nursing practice, including identifying clinical research priorities, service planning, analysis of professional characteristics and competencies, developing education programmes, and exploring clinical skills (Powell, 2003; Michels et al., 2012). The methods deployed in each Delphi study are dependent on its aims, but a classical Delphi study begins with a round of open-ended questions designed to gather rich data (Hasson and Keeney, 2011). This initial data is analysed and used to formulate questions or statements, which are then put to the panel for evaluation in subsequent rounds (Tappen, 2011). The process continues until a pre-determined level of consensus is achieved.

### Participants

Sampling is a fundamental methodological concern when using Delphi technique, as credibility depends on the perceived expertise of the panel (Green et al., 1999; Mead and Moseley, 2001; Cornick, 2006; Keeney et al., 2010). The panel's expertise was of fundamental importance to achieving the local aims of the research in supporting an innovative midwifery role expansion. Multiprofessional panels are preferable in Delphi technique surveys, to ensure no one professional interest dominates (Hutchings and Raine, 2006). The criteria for inclusion on this study's panel of experts was: (1) *For ECV practitioners*: working or having worked in a breech clinic and/or taking referrals from colleagues to perform ECVs. (2) *For sonographers*: involvement in university-level teaching of obstetric sonography.

### Data collection and analysis

The study took place between April 2013 and March 2014. FluidSurveys on-line software was used to administer the surveys. A secure link to the survey was sent directly to each panellist's professional e-mail address, along with a participant information sheet containing a brief literature review. Answers were downloaded collectively on an Excel spread sheet containing only the participant's responses and identification code, whereas personal identities were kept in a separate file.

The first and second rounds of the survey were piloted within the sponsoring hospital by a multiprofessional team including members of similar specialities, familiar with the aims of the research and its intended use in practice innovation, but less experienced clinically than the actual panel members. The analysis of the first round data and the design of the second round survey was validated by a senior obstetric registrar within the hospital, and the research supervision team, who also reviewed the third round prior to deployment. At all points, the practical purpose of the research – the development of an appropriate training and maintenance programme for midwife practitioners of ECV – guided the survey design.

In line with classic Delphi method, the first round of the survey contained mostly open-ended questions. The exceptions were two questions regarding whether the standards for achieving and maintaining competence should be the same for doctors and midwives. The consensus response to this issue had implications for the way the rest of the survey would be designed, and how much of the existing obstetric training programmes should be considered relevant to midwifery ECV training. Content analysis of the open-ended questions was performed line-by-line, by hand. Responses from the first round were compiled and aggregated under two practice themes (ECV skills and ultrasound skills) and three professional standards categories (training, maintenance and updating).

Initial analysis indicated that almost all of the core competencies suggested for ECV and basic third trimester ultrasound mapped to those included in the Royal College of Obstetricians and Gynaecologists' Objective Structured Assessment of Technical Skill (OSATS) (RCOG, 2007, 2009), represented in Table 1. This was a reassuring correspondence (Hasson and Keeney, 2011). A few additional competencies were suggested which were not directly included in the RCOG OSATS. The second round then sought the group's opinion on whether the RCOG's model was appropriate to apply in the training of midwives, as well as testing the value of the additional areas of competence identified in the analysis.

Further second round questions arose from the additional data concerning professional standards. Some participants in the first round suggested that competent performance of a minimum number of the tasks at hand was an appropriate standard to set. Therefore, some second round questions concerned quantifying, such as asking participants to identify a minimum number of ECVs

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