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'Oh no, no, no, we haven't got time to be doing that': Challenges encountered introducing a breast-feeding support intervention on a postnatal ward

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ABSTRACT

Objective: to identify elements in the environment of a postnatal ward which impacted on the introduction of a breast-feeding support intervention.
Design: a concurrent, realist evaluation including practice observations and semi-structured interviews.
Setting: a typical British maternity ward.
Participants: five midwives and two maternity support workers were observed. Seven midwives and three maternity support workers were interviewed. Informed consent was obtained from all participants. Ethical approval was granted by the relevant authorities.
Findings: a high level of non-compliance with the intervention was driven by a lack of time and staff, and the ward staffs' lack of control of the organisation of their time and space. This was compounded by a propensity towards task orientation, workload reduction and resistance to change – all of which supported the existing medical approach to care. Limited support for the intervention was underpinned by staff willingness to reconsider their views and a widespread frustration with current ways of working.
Key conclusions: this small, local study suggests that the environment and working conditions on a typical British postnatal ward present significant barriers to the introduction of breast-feeding support interventions requiring a relational approach to care.
Implications for practice: midwives and maternity support workers need to be able to control their time and space, and feel able to provide the relational care they perceive that women need, before breast-feeding support interventions can be successfully implemented in practice. Frustration with current ways of working, and a willingness to consider other approaches, could be harnessed to initiate change that would benefit health professionals and the women and families in their care. However, without appropriate leadership or facilitation for change, this could alternatively encourage learned helplessness and passive resistance.

Introduction

This article reports the findings of a qualitative evaluation of the implementation of a breast-feeding support intervention on a postnatal ward in the United Kingdom (UK). The evaluation sought to identify elements in the ward environment which supported or militated against embedding the intervention. The environments into which interventions are placed are increasingly thought to influence outcomes (Schmied et al., 2009). However, trials of complex interventions such as breast-feeding support initiatives often provide insufficient data on the research settings to be able to explain any negative or unanticipated outcomes (Medical Research Council, 2006; Oakley et al., 2006; Hoddinott et al., 2010).

UK, Australian and Swedish studies all describe postnatal wards as bureaucratic, stressful, task-orientated environments where midwifery encounters with women are often formulaic and brusque (Deery, 2005; Lindberg et al., 2005; Dykes, 2006; McKellar et al., 2009). This is likely to make introducing support interventions, which require a more relational approach to care, particularly challenging. The breast-feeding support intervention evaluated here was aimed at young

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women aged 20 and under. It was developed after conducting detailed literature reviews (Hunter, 2014), and analysing the breast-feeding support needs of young mothers using data from focus groups with young mothers themselves and an e-questionnaire with maternity staff (Hunter and Magill-Cuerden, 2014; Hunter et al., 2015). Key personnel in the study location were also consulted. The intervention comprised training midwives and maternity support workers (MSWs) to deliver structured, proactive breast-feeding support using a series of checklists. A four-bedded bay was set aside specifically for young mothers to facilitate delivery of the intervention and encourage peer support. To supplement the support provided by ward staff and provide continuity of carer, known family nurses were informed when young mothers on their caseloads were admitted to the ward and encouraged to come and visit them.

Literature review

Challenges encountered implementing interventions are not often the focus of research papers. There is evidence, however, of a tendency amongst midwives not to support research interventions.

Hoddinott et al. (2011) conducted interviews with researchers involved in the nine UK randomised controlled trials (RCTs) of breast-feeding interventions conducted between 2000 and 2011, none of which reported significant improvements in breast-feeding rates. Participants commented that they had assumed staff would be committed to the research process but met midwifery ambivalence regarding their project or breast feeding more generally, and difficulties procuring midwifery participation. A high workload and a lack of resources in the maternity service were thought to contribute to these findings.

During Hoddinott et al.'s (2010) own RCT investigating the provision of community breast-feeding support groups, prospectively gathered quantitative and qualitative data indicated that, where breast-feeding rates fell, participants reported staff shortages and organisational change resulting in high workload, low morale and a 'can't do' attitude. Managers in areas with declining breast-feeding rates focussed on addressing staffing issues rather than leading the research initiative. All of the study localities reported problems securing midwifery support and involvement to recruit women, facilitate groups and attend steering meetings.

Two action research projects with innovations, Deery (2005) in the UK and McKellar et al. (2009) in Australia, also found problems in commitment and involvement from midwives. Deery indicates hostility towards the researcher which she considered was displaced anger with lack of managerial support and other organisational changes, whilst McKellar et al. found anger and resentment at changes in postnatal care. Both studies indicate midwives were experiencing stress and heavy workloads. McKellar et al. identify a paucity of change ownership and suggest that adding research implementation to an already burdensome workload was overwhelming. In this study a negative culture in midwifery practice impeded the changes required to improve postnatal care.

In Swedish research looking at midwives' experiences of organisational and professional change, a new early discharge policy was introduced alongside an extended home visiting role for midwives (Lindberg et al., 2005). Although midwives were anxious and felt a sense of loss following the change, they were proud and satisfied with the new system. It is possible the more negative responses elsewhere may result from midwives feeling trapped in a changed system in which they can see no benefits for themselves or the women they care for. Research interventions in locations experiencing organisational changes, high workloads and low staff morale appear to become outlets for anger and frustration.

Methods

This evaluation formed part of a larger realist evaluation in which a breast-feeding support intervention was developed following focus groups with young mothers and an e-questionnaire distributed to maternity staff nationally and locally to the intervention setting. The intervention aimed to provide breast-feeding support to women aged 20 and under during their hospital stay.

A realist approach acknowledges the importance of context on outcomes, and seeks to identify the mechanisms or processes that are triggered when an intervention interacts with a particular environment (Pawson and Tilley, 1997). These mechanisms will support and promote either positive or negative outcomes. The realist evaluation framework consists of a four-stage process of theory (what is happening now and why?), hypothesis (what might work and why?), observation (what happens when) and revised programme specification (Pawson and Tilley, 1997; Kazi, 2003). The methods and findings presented in this article relate to the third stage of the process – observation – during which, following staff training, the intervention was implemented and a concurrent evaluation carried out. The evaluation was led by the first author of this paper and consisted of observations of practice and semi-structured interviews with ward staff, conducted over six months from October 2012–April 2013. As the evaluation was concerned with the implementation, rather than the content, of the intervention, young women themselves were not interviewed during this phase.

There is no set methodology for carrying out realist evaluations. Rather, the most appropriate methods for each situation are selected (Pawson and Tilley, 1997; Hoddinott et al., 2010). Observations are particularly suited to a realist approach, enabling the researcher to see what is happening at first hand (Donovan, 2006; Dykes, 2006). Observation may reveal more than might be reported in an interview, such as culturally learnt behaviour that may not be articulated (Agar, 1996; Dykes, 2006; Bowling, 2009). An unstructured design was used, facilitating an inductive approach whereby events, ad hoc discussions and comments were noted by hand in a field diary as, or just after, they occurred. By recording everything, the researcher hoped to mitigate the risk of bias associated with observational enquiries (Bowling, 2009).

In order to capture influences of context on the intervention at different time points, three six-hour observations were conducted – one at the beginning, one in the middle and one towards the end of the six month evaluation period. The six-hour time period covered the length of a short shift. All observations were carried out during the day time, as this was the busiest time on the ward when most decisions regarding the intervention were likely to be taken. To reduce bias, ward staff were given verbal and written information about the evaluation but had no advance notification of the observation dates. During the observations, five midwives and two MSWs who consented were followed by the researcher as they cared for young and older women. The researcher attempted to adopt a 'peripheral' status, blending into the environment as much as possible to limit the effects of her presence on the behaviour of those being observed (Burns et al., 2012). The researcher's 'insider status' as a midwife working in another area of the Trust, and her frequent presence on the ward while the intervention was being set up, meant that most staff were used to and appeared comfortable with her presence. Assurances were given regarding participant anonymity and the independence of the research. Efforts were made to build trust and put staff at ease.

Following the observations, the field diary was read and re-read by the researcher in order to identify themes. Data were then cut and sorted, creating a thematic scrapbook. Where links between themes were identified, they were joined together to form more abstract categories of behaviour patterns. Analyses of