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The impact of outpatient priming for induction of labour on midwives' work demand, work autonomy and satisfaction

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ABSTRACT

Background: Induction of labour often begins with the application of a priming agent to soften the cervix, generally requiring women to stay in hospital overnight (inpatient priming). An alternative is outpatient priming by a midwife, where women are allowed to go home following priming. This approach has the potential to impact, either positively or negatively, on the midwives involved.
Question: To what extent did the introduction of outpatient priming influence midwives' work demands, work autonomy, stress and job satisfaction.
Methods: A before–after study (with two separate cross-sectional samples) was conducted alongside a randomized controlled trial of outpatient versus inpatient priming, conducted at two metropolitan teaching hospitals in Australia. Midwives completed a questionnaire before the introduction of outpatient priming and again approximately two years later.
Findings: 208 midwives participated (response rates-time 1:81% (87/108); time 2:78% (121/156)). A mixed model analysis test of pre-post intervention differences found no changes in work demand, work autonomy and satisfaction. At time 2, over 80% of midwives reported that the introduction of the practice had reduced or made no difference to their work stress and workload, and 93% reported that outpatient priming had increased or had no impact on their job satisfaction. Furthermore, 97% of respondents were of the opinion that the option of outpatient priming should continue to be offered.
Conclusion: Results suggest that outpatient priming for induction of labour is viable from a midwifery practice perspective, although more research is needed.

1. Introduction

Induction of labour is an increasingly common intervention worldwide,[1–3] often requiring the application of an induction agent to 'prime' or soften the cervix.[4] In South Australia, where 30% of all labours are induced,[5] the usual practice of priming for induction of labour is for women to stay in hospital overnight. Another method is to allow the woman to go home after priming (outpatient priming), rather than staying in hospital, with several studies demonstrating the feasibility of using this approach.[6–8] The prospect of outpatient priming has been the subject of a recent Cochrane review[1] and also examined in the UK NICE guidelines on intrapartum care.[9]

In many Australian hospitals, cervical priming is the responsibility of midwives. Under the 'usual care' conditions of inpatient cervical priming, women are admitted to the labour ward where midwives assess the cervix, perform at least 20 min of electronic monitoring to confirm fetal well being (CTG) and then apply the vaginal priming agent. This is followed by at least 20 min of electronic monitoring. Midwives then settle the woman for the night, and check on her at least once. After an overnight stay, most of these women will require artificial rupture of membranes (amniotomy) the following morning, often followed by an oxytocin infusion to begin their contractions.

Outpatient priming follows a similar process to inpatient priming, however with additional responsibilities for the midwife. Following cervical priming a longer period of electronic monitoring (at least 40 min) is performed. The midwife then determines

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whether the CTG is satisfactory in order to allow the woman home to rest overnight. If not, the midwife seeks advice from the doctors. The midwife also provides education and information to women as to when to come back to hospital. Women are advised that they may call midwives or return to hospital at any time should they become too uncomfortable or anxious. Women are to represent to hospital the following morning for admission or if labour commences, that night.

The prospect of outpatient priming in an Australian context was explored with a randomized controlled trial in South Australia. The clinical trial aimed to compare the two methods of priming for induction of labour: (1) inpatient priming (usual care), and (2) outpatient priming (intervention group). The primary aim of the trial was to compare outcomes for mother and baby between the two groups. The introduction of outpatient priming also means changes to midwives' practice, with these changes potentially impacting on the midwives involved. Therefore a survey was planned to occur alongside the randomized controlled trial to assess the impact of outpatient priming on midwives, and is the subject of this paper.

2. Background

As with any organisational change the introduction of outpatient priming may affect a number of aspects of midwives' working lives, such as changes in responsibilities, interprofessional relationships, workload, work schedules and job satisfaction. For example, outpatient priming places increased clinical responsibility on midwives in terms of undertaking the priming process (a new procedure for midwives not working in the labour ward), determining whether or not women are able to return home dependent on CTG readings and responding to any concerns women may have once they leave hospital. Changes in responsibility could potentially affect midwives' autonomy. Furthermore, outpatient priming could increase midwives' workload, or potentially decrease workload due to not having to care for women in hospital. Together these changes may affect midwives' stress and job satisfaction, and subsequently turnover and retention of midwives should outpatient priming be introduced more widely. For example, in a review of the literature McCarthy et al.[10] identified a range of organisational variables that correlated with turnover in nursing and midwifery, including "instrumental communication, professional latitude and autonomy, quality of work-life, relationship with one's supervisor, routine, perceived status and job content" (p. 40). Working hours, workload and work schedules have also been found to influence retention and turnover in midwifery.[11,12] Job dissatisfaction has been identified as perhaps the most significant reason nurses and midwives leave their profession.[10]

In relation to midwives' reasons for staying in the profession, a recent study by Sullivan et al.[13] found that job satisfaction was experienced "when midwives felt that they made a difference to women, had positive interactions with women in their care and saw women happy" (p. 331). Watson's[14] Australian survey of Victorian midwives also identified the importance of positive interactions with women to midwives' job satisfaction. In studies of outpatient priming where women's satisfaction was examined, women preferred outpatient priming to inpatient priming.[15,16] Midwives can play a significant part in supporting eligible women with this option, which may lead to increased job satisfaction.

The introduction of outpatient priming could positively or negatively affect the working lives of the midwives involved in providing care to women during priming; however we could find no published research on the impact of outpatient priming on midwives. In this paper we address this gap by exploring the impact (both positive and negative) of the introduction of outpatient priming on the work undertaken by midwives.

3. Participants and methods

3.1. Aim

The aim of this study was to examine whether the introduction of outpatient priming affected midwives' work demands, work autonomy, stress and job satisfaction. The study was conducted alongside a randomized controlled trial of outpatient versus inpatient priming.

3.2. Clinical study

The randomized controlled trial was conducted in South Australia at the two obstetric metropolitan teaching hospitals over the period 2008–2011. Eligibility for the trial was restricted to women with healthy singleton pregnancies who were being induced for post-dates (past 40 weeks) or social (i.e., non-medical) reasons, and who were at low risk of obstetric complications (Australian New Zealand Clinical Trials Registry ACTRN12608000249358).

3.3. Midwives' survey

3.3.1. Study design

A quasi-experimental cross-sectional study was undertaken using a before and after questionnaire to assess the impact of outpatient priming on midwives.

3.3.2. Participants

Prior to commencing the trial, midwives working in areas involved in priming were invited to seminars and in-services about the clinical study. Nursing unit managers were involved in the planning of the trial and were advised of the midwife surveys. All midwives (permanent staff) at both hospitals who worked in areas where priming was performed were encouraged by their nursing managers to complete the questionnaire. These were midwives who were administering priming gels and/or taking care of women who had been given the gels. Participating midwives worked predominately in the labour ward, midwifery group practice (MGP) and outpatient women's assessment service (WAS). Before the study commenced it was not clear whether group practice midwives would be participating in the trial at one of the hospitals (MGP1) and so these midwives did not receive the pre-trial survey (they participated in the study two months later and received the post-trial survey). A few midwives also gave priming gels on the antenatal ward in one of the hospitals.

Questionnaires were distributed two weeks before the trial started at the hospitals (August and October 2008) and again approximately two years later, near the end of the recruitment period (November 2010). In both surveys, questionnaires were placed in individual mailboxes after determining from rosters the midwives who would be working over the two-week period. The questionnaires remained in their mailboxes for approximately two to three weeks to allow midwives time to complete the survey if they were rostered to work at least once during that time period.

3.3.3. Survey instrument

The midwives' questionnaire sought responses on several measures of work autonomy, job demands and job satisfaction. These measures were derived from existing measures that have previously been applied in studies of healthcare workers, including nurses, and have demonstrated good reliability and validity (Chronbach alpha coefficients were equal to or higher than .75, test–retest reliability was at least .55).[17,18] Given that the original