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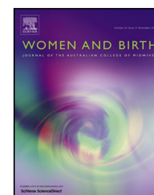

Working in caseload midwifery care: The experience of midwives working in a birth centre in North Queensland

Marissa C. Edmondson [a,*], Sandra B. Walker [b]

[a] The Townsville Hospital, 100 Angus Smith Drive, Douglas, QLD 4814, Australia
[b] Central Queensland University Rockhampton, Bruce Highway, North Rockhampton, QLD 4702, Australia

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ABSTRACT

Background: Pregnancy, birth and child rearing are significant life events for women and their families. The demand for services that are family friendly, women focused, safe and accessible is increasing. These demands and rights of women have led to increased government and consumer interest in continuity of care and the establishment in Australia of birth centres, and the introduction of caseload midwifery models of care.
Aim: The aim of this research project was to uncover how birth centre midwives working within a caseload model care constructed their midwifery role in order to maintain a positive work–life balance.
Methods: A Grounded Theory study using semi-structured individual interviews was undertaken with seven midwives who work at a regional hospital birth centre to ascertain their views as to how they construct their midwifery role while working in a caseload model of care.
Findings: The results showed that caseload midwifery care enabled the midwives to practice autonomously within hospital policies and guidelines for birth centre midwifery practice and that they did not feel too restricted in regards to the eligibility of women who could give birth at the centre. Work relationships were found to be a key component in being able to construct their birth centre midwifery role. The midwives valued the flexibility that came with working in supportive partnerships with many feeling this enabled them to achieve a good work–life balance.
Conclusion: The research contributes to the current body of knowledge surrounding working in a caseload model of care as it shows how the birth centre midwives construct their midwifery role. It provides information for development and improvement of these models of care to ensure that sustainability and quality of care is provided to women and their families.
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1. Introduction

Midwifery continuity of care models, such as caseload or group practice are becoming increasingly popular maternity care choices for Australian women.[1] Research has shown many benefits of this model of care including increased satisfaction for women, lower rates of caesarean section and epidurals and higher rates of breastfeeding.[1] Such findings are important to midwifery practice and support the caseload or group practice models of midwifery care that have been established at many locations around Australia.[1]

These midwifery models of care enable midwives to be responsible for a woman's care during pregnancy, labour, birth and the postnatal period.[1] In caseload or group practice models of care the woman becomes familiar with her assigned midwife and other midwives in the same group practice who may be on call at the time of the birth.[1] The women who are eligible for this model of care must have no identified medical, obstetric or foetal risk factors, which would be expected to inhibit their ability to give birth safely and usually live in the defined catchment area serviced by the health care facility that supports the midwifery continuity of care model.[1,2] Midwives working in a caseload model of care work whatever hours are required to provide care to the women[1] and therefore need to establish strategies that enable the maintenance of a positive work–life balance.

There have been many studies undertaken that have reviewed caseload midwifery and what this brings to the birth experience of women[3–5] however only a few have explored how midwives experienced and manage their work–life balance within a caseload model of care.[6–9] Much of the literature on caseload midwives and work–life balance originated in the United Kingdom. The research team of Stevens and McCourt[4] were earlier explorers of this issue and in 2002 published a series of papers that explored the

* Corresponding author. Tel.: +61 07 4433 2995.
E-mail addresses: marissa.edmondson@health.qld.gov.au, fasteddo@bigpond.net.au (M.C. Edmondson).

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strengths and weakness of a midwifery caseload model of care. Data was collected via survey and interviews with midwives and these researchers found midwives valued job satisfaction, peer support and opportunity to develop skills as being key strengths of the caseload midwifery model of care, while negative features, included lack of child care, poor management support, long hours and demanding women.[4] The later UK study by Hunter[9] found that the midwife–woman relationship established as a result of caseload midwifery models of care was the most rewarding aspect of the midwife's job.[9] This view was support by the outcomes of Thorgen and Crang-Svalenius[7] research. These researchers interviewed UK birth centre midwives working in a caseload model of care and found they had developed professionally and had increased confidence since beginning work in the birth centre. In a more recent study on this topic Australian researchers, Collins et al.,[8] distributed questionnaires over an 18-month period to midwives working in a metropolitan midwifery group practice (MGP) or caseload midwifery model of care. These researchers found that building relationships with women, providing continuity of care and practising autonomously provided caseload midwives with great job satisfaction.[8] These findings were supported by the results of a qualitative research study undertaken by Fereday and Oster[10] who interviewed 17 midwives working within a caseload model of care in Adelaide, Australia. These researchers found caseload midwifery enabled midwives to experience both positive and negative feelings regarding the establishment of their work–life balance.[10]

Further searching of the literature databases failed to find any Australia literature that looked at the experience of regionally placed birth centre midwives working in caseload midwifery models of care or how this group constructed their midwifery role. As a consequence the aim of this research project was to uncover how Australian birth centre midwives working within a midwifery caseload model care constructed their midwifery role in order to maintain a positive work–life balance. The study was guided by the research question "How do birth centre midwives construct their midwifery role within the confines of hospital policy and work unit relationships while maintaining a positive work–life balance?".

2. Methods

This study was guided by the principles of Grounded Theory which focuses on human interaction and social processes.[11] The use of Grounded Theory methodology enabled the researchers to conceptualise the research information and develop a detailed description of the phenomenon under investigation.[11] The research design consisted of face-to-face interviews, constant data analysis and memoing to address the research question posed by this qualitative study. The use of this research approach was consistent with Grounded Theory methodology as it enabled the meaning of participants reality, events and phenomena to be uncovered thereby facilitating the reporting of detailed descriptions of the experiences under investigation.[12] In addition this approach provided the researchers with the opportunity to reflect on features of the participants reality and to develop an understanding of how they view and give meaning to their world.[12]

The study conformed to the principles outlined in the Australian Code for Responsible Conduct of Research[13] with approval received from both the university and health care agency Human Research Ethics Committees (HREC) prior to the commencement of data collection.

3. Setting and midwifery model of care

The birth centre where the study participants worked is situated in North Queensland, Australia. It is an independent structure located on hospital grounds and is attached via an independent hallway to the main hospital. Women are able to access the birth centre without entering the main hospital building. The birth centre follows a midwifery-led collaborative caseload model of care. In this model of care the birth centre midwives work in partnerships to provide holistic midwifery care to their allocated women and families throughout the pregnancy continuum. Eligible women are allocated to a midwife who they have either seen before or if their estimated date of birth falls where the midwife has availability. There are two midwives in each partnership and women are only shared between the two midwives when on call or on holiday leave. A full-time midwife working a 38 h week will carry a caseload of 40 women and those working part-time are designated a caseload on a proportional basis. Hours of work are organised by the midwives, providing that they meet the needs of their women. The midwives are not required to work more than 8 h and can choose to hand over their women after 8 h. They have the discretion to work up to, but not longer than 12 h to meet their women's needs. Each caseload midwife is required to have a period of at least 8 h within a 24 h period where they are continuously free of duty. They must also have approximately 4 days off duty per fortnight with at least 2 consecutive days off. These midwives receive a salary and use time sheets to log their hours. There is flexibility with working hours through the use of time off in lieu (TOIL). Midwives are able to adjust their time worked over an 8-week work cycle. All midwives working in this model are entitled to 6 weeks recreation leave, which must be taken in a large block. The birth centre does not offer foetal cardiotocography (CTG) monitoring or epidural pain relief but does have facilities for water immersion/births and midwives are able to offer women narcotic pain relief. If the woman requires further pain relief or develops complications she is transferred to the hospital birth suite where her midwife can choose to stay or hand over care to birth suite staff, providing they have not worked past 12 h. Each birth centre midwife is also required to incorporate 40 h of complex care every six months to maintain complex clinical skills. The Australian College of Midwifery (ACM) National Midwifery Guidelines for Consultation and Referral[2] are adhered to and there is collaborative case conferencing on a weekly basis with the birth centre midwives, the unit manager and a Consultant Obstetrician.

4. Participants

Purposive sample was used as all nine midwives who worked at the selected birth centre were invited to participate in the study, which was conducted from March to June 2012. Eligibility for inclusion in this study required participants be midwives who were currently employed full-time or part-time at the selected regional hospital birth centre and have three years experience or less of working in the birth centre caseload model of care. These inclusion criteria enabled the capturing of data from those midwives who were more experienced with the caseload model of care as well as those just entering the work setting.

4.1. Data collection

Data was collected via a single, semi-structured, individual interview. Before commencing the interviews each participant was given a letter explaining the purpose of the study and asked to complete a written consent form indicating their willingness to participate in the research project and to the taping of the interview. The interviews were conducted at a time and place that was suitable for both the interviewer and interviewee.

Five key questions were asked of participants. These questions correlated with the National Maternity Services Plan

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