Women and Birth (2011) 24, 65–71

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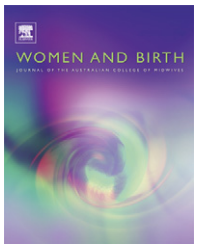

Foetal monitoring: A woman-centred decision-making pathway

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Received 13 April 2010; received in revised form 11 August 2010; accepted 19 August 2010

KEYWORDS
Midwifery;
Evidence based practice;
Foetal monitoring;
Decision making;
Pregnant women

Summary
Problem: Many midwives continue to use continuous foetal monitoring on low risk women in labour, despite evidence based clinical guidelines to the contrary. Continuous foetal monitoring has been linked to increased rates of medical intervention during labour and birth with no improvement in long term neonatal outcomes.
Participants: Midwives who used continuous foetal monitoring on low risk women in labour at two regional Queensland hospitals.
Methods: This Grounded Theory study explored midwives' decision-making processes related to the use of continuous electronic foetal monitoring on low risk labouring women. Primary data were gathered in semi-structured interviews with five purposively selected midwives and concurrently analysed using Grounded Theory techniques of theoretical sampling and constant comparison.
Findings: The midwives made the decision that led to continuous electronic foetal monitoring on low risk women at two key decision points during labour care; the first during the midwives' initial assessment of the woman and foetus, and the second when the midwives categorised the women as high or low risk. However, various factors impacted on these decisions including trust and staff workloads within a context of risk management and medical dominance. There was limited opportunity for women to be involved in the decision-making process about foetal monitoring and only partial information was provided prior to cardiotocography.
Conclusions: Consistent with current clinical guidelines which recommend open, consultative discussion with the woman about foetal monitoring and a partnership approach towards decision-making following informed choice, a woman-centred foetal monitoring decision-making pathway is proposed. This pathway is applicable in midwifery education, research and clinical practice to promote both evidence based practice and woman-centred decision-making.
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doi:10.1016/j.wombi.2010.08.003

Introduction

This paper reports on a Grounded Theory study that set out to investigate the clinical practice of using continuous electronic foetal monitoring (CEFM) on low risk labouring women, contrary to evidence based clinical guidelines,[1,2] and to examine the complex interplay in midwives' clinical decision-making regarding CEFM. For the purposes of this study, 'low risk' referred to any pregnancy with no identified maternal or foetal medical condition.

The outcomes of the study include a pathway that explains midwives' decision-making on CEFM, and a new woman-centred electronic foetal monitoring decision-making pathway to increase women's participation in decision-making regarding foetal monitoring methods whilst upholding evidence based practice.

Literature review

Foetal monitoring is accepted as a critical component of labour care. Intermittent auscultation, the traditional method of monitoring foetal health during labour, has been shown to be easy and efficient, resulting in improved peri-natal mortality and morbidity.[3,4] However much more data became available to clinicians by using CEFM following its introduction in the late 1950s,[5] even though there is continued disagreement over the interpretation of CEFM traces.[6,7] Controversy has been raised about the increased rates of medical interventions associated with CEFM use, without the benefit of improved long term foetal outcomes.[8–10] The use of CEFM is supported for women experiencing high risk pregnancies, though this remains controversial for low risk labouring women.[11–13] Evidence based clinical practice guidelines have been developed to guide health professionals' decision-making in relation to CEFM,[2,11–13] though these address only one element in a complex process and the guidelines may not be followed. For example, a recent New Zealand audit of almost 200 randomly selected medical records found that approximately half of the women eligible for intermittent auscultation were monitored with some form of electronic foetal monitoring and almost 40% had an admission cardiotocograph (CTG) despite there being no clinical indications.[14]

The complex cognitive processes in decision-making have been studied by researchers in pcychology and health disciplines such as nursing,[15,16] midwifery[17,18] leading to the development of a wide range of theoretical and professional decision-making frameworks.[19,20] Three broad categories of approaches to decisionmaking have been proposed: (1) normative approaches assume the individual is logical, rational and focus on how decisions are made in an ideal world, and the quality of a decision, based on outcome, (2) descriptive approaches focus on how decisions are made;the process of decision making, and how individuals reach that decision and (3) prescriptive approaches aim to improve the individual's decisions by focusing on how decisions are formulated.[20]

Two key studies of midwives' decision-making used a descriptive approach to study specific acute[21] and complex[17] clinical situations. These studies found that expert midwives used a blend of theoretical and experiencial knowledge, with heuristics (probability judgements based on memory and clinical experience) also being used by more experienced midwives.[17] However, the amount of clinical experience required to develop such strategies is contentious.[22] This study also used a descriptive approach to explore decision-making by both novice and experienced midwives. The period of 5 years midwifery experience as the point of differentiation, rather than the shorter period of 2 years used in Haggerty's study,[21] as midwives at the study sites worked across the continuum of midwifery care, not only in birth suite. Thus increasing the amount of clinical experience in birth suite for categorising the 'experienced' midwife.

Participants and methods

A qualitative approach guided this study to enable the complexity of decision-making processes to be explored.[23] Grounded Theory, according to Strauss and Corbin, facilitated the collection and analysis of a wide variety of descriptive data and associated variables, to ensure that the theory generated is valid and reliable.[24] The study participants were midwives recruited purposively from two regional Queensland hospitals with birth suites equipped with CEFM equipment. Ethical approval was obtained from the health district and university ethics committees prior to commencement of the study.

The primary source of data was five midwives who had used CEFM on low risk labouring women and those women's health records. A data collection tool and subsequent health record audit assisted the identification of low risk labouring women. When an appropriate case was identified, the Nurse Unit Manager, an expert midwife, was consulted to confirm the low-risk assessment. The situations which led to the low risk woman being monitored with CEFM are outlined in Table 1 with the list of participants. The participants were invited to participate in a semi-structured, audio-taped interview,

Table 1 Midwife participants.

Participants (Pseudonyms)	Situation leading to CEFM (data from labouring women's health record)
1. Iris > 5 years experience	Helping out in a busy labour ward. CTG used for a baseline recording. When another midwife took over, CTG was left on.
2. Dorothy > 5 years experience	CTG used for an admission trace, used during a busy shift — not taken off.
3. Julliette > 5 years experience	Even though the woman met low risk criteria, suspected something not quite right and therefore used CEFM from admission. Later discovered woman had a UTI — antibiotics commenced during labour.
4. Kaitlyn < 5 years experience	Primiparous woman with possible rupture of membranes during early labour.
5. Amber < 5 years experience	Multiparous woman with possible rupture of membranes during early labour.

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