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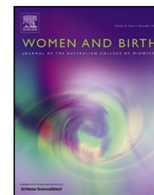

Original Research - Qualitative

Teamwork among midwives during neonatal resuscitation at a maternity hospital in Nepal

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ABSTRACT

Problem: The ability of health care providers to work together is essential for favourable outcomes in neonatal resuscitation, but perceptions of such teamwork have rarely been studied in low-income settings.
Background: Neonatal resuscitation is a proven intervention for reducing neonatal mortality globally, but the long-term effects of clinical training for this skill need further attention. Having an understanding of barriers to teamwork among nurse midwives can contribute to the sustainability of improved clinical practice.
Aim: To explore nurse midwives' perceptions of teamwork when caring for newborns in need of resuscitation.
Methods: Nurse midwives from a tertiary-level government hospital in Nepal participated in five focus groups of between 4 and 11 participants each. Qualitative Content Analysis was used for analysis.
Findings: One overarching theme emerged: *looking for comprehensive guidelines and shared responsibilities in neonatal resuscitation to avoid personal blame and learn from mistakes*. Participants discussed the need for protocols relating to neonatal resuscitation and the importance of shared medical responsibility, and the importance of the presence of a strong and transparent leadership.
Discussion: The call for clear and comprehensive protocols relating to neonatal resuscitation corresponded with previous research from different contexts.
Conclusion: Nurse midwives working at a maternity health care facility in Nepal discussed the benefits and challenges of teamwork in neonatal resuscitation. The findings suggest potential benefits can be made from clarifying guidelines and responsibilities in neonatal resuscitation. Furthermore, a structured process to deal with clinical incidents must be considered. Management must be involved in all processes.
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Statement of significance

Problem or issue

The ability of health care providers to work together is essential for favourable outcomes in neonatal resuscitation, but barriers to effective teamwork have rarely been studied in low-income settings.

What is already known

Training in neonatal resuscitation skills in maternity health care facilities has the potential to significantly reduce neonatal mortality. To accomplish long-term sustainability of these clinical skills more research is needed.

What this paper adds

Teamwork in neonatal resuscitation in low-income settings can benefit from displaying comprehensive protocols and from clarifying responsibilities. Both processes need management involvement.

Abbreviations: SBA, Skilled Birth Attendant; HBB, Helping Babies Breathe; PMWH, Paropakar Maternity and Women's Hospital.

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1. Introduction

Every year, an estimated 2.9 million newborns die in the neonatal period, which is defined as the first 28 days of life. Three-quarters of those deaths occur in the first week and the highest risk exists on the very first day of life. The burden is greatest in low- and middle-income countries, which account for 99% of all neonatal deaths.[1] A number of evidence-based and cost effective interventions during the neonatal period could prevent up to 70% of the deaths, provided that they are implemented under ideal conditions.[2] These interventions range from providing a clean birth and immediate resuscitation of a non-breathing newborn to preventing hypothermia and promoting early breast-feeding.

A study at Paropakar Maternity and Women's Hospital (PMWH) in Nepal tested the hypothesis that introducing a simplified protocol for neonatal resuscitation called Helping Babies Breathe (HBB) can reduce perinatal mortality[3] and found that the intervention significantly decreased the intrapartum stillbirth as well as first-day mortality.[4] Resuscitation is considered an important intervention when the newborn does not initiate and sustain breathing after birth. Meta-analysis of several trials estimate that there is a potential for reducing global neonatal mortality rates by up to 30% among term and up to 15% among pre-term babies born at facilities where training in neonatal resuscitation has been implemented.[5] Many independent trials in low-resource settings have introduced training in resuscitation together with other newborn care interventions, effectively reducing neonatal mortality.[6] However, the long-term effect and sustainability of these results on mortality outcomes from resuscitation training alone needs further attention and research.[7]

Initiation of early resuscitation, and especially ventilation, is crucial for the hypoxic baby to survive.[8] The midwife or birth attendant working closest with the mother and her newborn is central to determining the quality of care that is provided and thus the outcome.[9] In order to evaluate what occurs on the resuscitation table, quantitative methods can be used to measure, for example, time to intervention, oxygen saturation levels, Apgar scores and mortality outcomes. However, the personal experiences of the staff involved as well as various group dynamics will also affect the steps taken to resuscitate the child. The ways in which a group of people work and communicate together is often referred to as teamwork.[10]

The importance of teamwork in newborn care has been studied before, but qualitative data, especially from low-income settings, is limited. Focus group discussions with staff from a neonatal ward in the USA found that provider characteristics, such as personality, reputation and expertise as well as organization and working environment, are important for a well-functioning team.[11] Another study from a neonatal facility in south-central USA proposed that professional attitudes, maintaining relationships and having concurrence about the team's goal are factors that influence teamwork.[12] Looking at resource-limited settings, other specific factors can create barriers and can affect the quality of care provided for newborns.[13] For example, a study among providers of neonatal resuscitation in Malawi suggested that experience and knowledge of this important intervention was in place, but that the lack of equipment and standard protocols or ethical considerations could nevertheless form substantial barriers for its use.[14]

The aim of this study is to explore nurse midwives' perceptions of teamwork when caring for a newborn in need of resuscitation in a low-income setting.

2. Participants, ethics and methods

2.1. Study setting

Paropakar Maternity and Women's Hospital is a tertiary-level government hospital providing gynaecological and obstetrics services in Kathmandu, Nepal. It serves as a central referral hospital and training site for reproductive health, including neonatal health, for the country and employs 641 staff. Every year approximately 22,000 births take place at the hospital. In 2012, when this study was performed, the early neonatal mortality rate was 9 per 1000 live births and the stillbirth rate was 19 per 1000 births.[4]

The hospital has an admission unit, a labour room where potentially complicated births take place, a birth centre for uncomplicated births, an operation theatre, an antenatal care unit, a maternal intensive care unit and a postnatal ward. The resuscitation of infants, when necessary, takes place in the admission room, the labour room, and the birth centre, and, in the case of caesarean section, the operation theatre. Each of these wards have one or more resuscitation tables designated for that purpose.

To date, Nepal does not have legislation in place to define and regulate the education of midwives according to the standards of the International Confederation of Midwives.[15] However, the Nepal Nursing Council oversees the regulation of various levels of education of the nursing staff who provide midwifery care throughout Nepal. The Ministry of Health and Population in Nepal also have a long-term goal to develop midwifery training and leadership in maternity care.[16]

Nurses with varying levels of education and experiences perform the immediate care for all newborns at the hospital. Most nurses have completed a three-year programme to obtain a Proficiency Certificate Level (PCL) in nursing. After completing two years of post-qualifying working experience, they earn a bachelor's degree in nursing. Some of them move on to complete a master's degree in nursing. In the obstetric wards, most of the nurses, regardless of academic level, have received Skilled Birth Attendant (SBA) training, which is a two-month training programme focusing on the care of mothers and newborns during birth. The SBA curriculum is a competency-based training programme and includes both practice and theoretical knowledge of the national neonatal resuscitation protocol.[16] In this study, nurse midwifes are those who have completed at least the Proficiency Certificate Level (PCL) in nursing education and are currently working in various units within the maternity hospital. The hospital also hosts many nurse students who are practising on the wards and who take an active part in assisting deliveries under the supervision of the qualified staff. Obstetricians and paediatricians are available on call but are not routinely present at deliveries.

2.2. Study design

To gain insights in how the team around the newborn thinks, communicates and acts together, focus group discussion was selected as the preferred method to collect data for analysis.[17] One group from each ward and one group consisting of supervisors was assembled with the ambition of including 6–8 participants in each group. The number of participants needed to be large enough to generate a meaningful group discussion but small enough for the moderator to facilitate the participation of all members.[18]

2.3. Ethical considerations

Participants signed a written consent form and were reassured that confidentiality would be respected before the discussion

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