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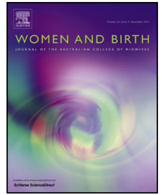

ORIGINAL RESEARCH – MIXED METHODS

An overview of the first 'no exit' midwifery group practice in a tertiary maternity hospital in Western Australia: Outcomes, satisfaction and perceptions of care

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ABSTRACT

Background: Midwifery group practice (MGP) is a care model offered by a primary midwife in a small team. Evidence confirms MGP is acceptable to women, safe and cost effective.
Methods: We aimed to provide a systematic overview of the first 'no exit' MGP in a Western Australian (WA) tertiary maternity hospital, using a mixed methods approach, involving four phases. Between July 2013 and June 2014: phase one assessed MGP characteristics, obstetric and neonatal outcomes by parity; phase two examined women's satisfaction by mode of delivery; and phase three qualitatively explored perceptions of care. Phase four compared the proportion of MGP women and the 2012 WA birthing population.
Findings: Phase one included 232 MGP women; 87% achieved a vaginal birth. Phase two included 97% (226 of 232) women, finding 98% would recommend the service. Phase three analysis of 62 interviews revealed an overarching theme 'Continuity with Midwives' encompassing six sub-themes: only a phone call away; home away from home; knowing me; a shared view; there for me; and letting it happen. Phase four compared the MGP cohort to 33,393 WA women. Intrapartum MGP women were more likely than the WA population to have a vaginal birth (87% vs 65%, $P \leq 0.001$) and intact perineum (49% vs 36%, $P \leq 0.001$) and less likely to use epidural/spinal analgesia (34% vs 59%, $P \leq 0.001$), or have a caesarean (13% vs 35%, $P \leq 0.001$).
Conclusions: Mixed methods enabled systematic examination of this new 'no exit' MGP confirming safety and acceptability. Findings contribute to our knowledge of MGP models.
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Summary of relevance:

Problem or issue

No previous research was identified which used a variety of tools to examine the components within a newly evolving 'no exit' midwifery group practice for both maternity services and women.

What is already known

Evidence confirms midwifery group practice is acceptable to women, safe and cost effective.

What this paper adds

Mixed methods enabled a comprehensive examination of a newly evolving 'no exit' midwifery group practice, confirming it was a safe and acceptable to both the maternity service and women. By utilising this methodology we were able to provide a more informative and detailed overview of service characteristics.

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1. Introduction

Midwifery group practice (MGP) also known as caseload midwifery, refers to a model of care offered to a woman across the perinatal period, by a primary midwife embedded within a small group of midwives.[1–3] Traditionally, to be eligible for caseload midwifery care, women were required to be obstetrically and medically low risk.[2]

A Cochrane review comparing midwife-led continuity models to other models, found women receiving care within midwife-led continuity models were less likely to have an epidural, episiotomy, or assisted birth and more likely to have a spontaneous vaginal birth.[2] Additionally, outcomes from the Australian COSMOS study comparing women randomised to caseload midwifery or a standard midwifery service, found women receiving caseload midwifery were less likely to have a caesarean birth, an epidural, an episiotomy, or an infant admitted to a special care nursery (SCN).[4] Women with identified risks have also been included in MGP models with promising outcomes. The M@NGO study compared the outcomes of MGP and standard maternity care, for women of any risk, confirming no differences between these models in relation to mode of birth, epidural use, or neonatal complications.[5]

Additionally, Australian research has found care provided within an MGP model is more cost effective compared to standard care,[5] especially for selective groups of Australian women such as Aboriginal mothers[6] and low risk women.[3,7,8] How effectively MGP models meet Australian women's expectations has been explored by researchers, with evaluation being positive,[9] especially in relation to continuity of care and the personal and professional attributes of the midwife.[10]

The impact of parity and birth outcomes on maternal satisfaction have been examined. An English mixed methods study found primiparous women who have increased obstetric intervention such as induction of labour are generally less satisfied with their care.[11] Whilst an Irish prospective based questionnaire study, which compared satisfaction with vaginal birth and caesarean birth found women of any parity, prefer a vaginal birth and that maternal satisfaction with vaginal birth was high.[12] Australian research has found women who birth in the public sector had greater levels of satisfaction than women who birthed the private sector, especially if they received professional support within 10 days post discharge.[13]

In summary, MGP is acceptable to women, safe and cost effective. However, no previous research was identified which used a variety of tools to examine components within a newly evolving MGP model for both maternity services and women. This information is important if research around MGP is to be used to shape the future provision of maternity services and provide woman focused care. The aim of this study was to provide an informative, complete and balanced overview of the first MGP in a Western Australian (WA) tertiary maternity hospital, using a mixed methods approach, involving four phases. Phase one focused on the characteristics of the service obstetric and neonatal outcomes. Phase two examined women's satisfaction and involvement with their care. Phase three explored how women perceived their MGP care. Finally phase four compared the proportion of MGP women to WA women giving birth in 2012, for five selected obstetric outcomes.

2. Methods

2.1. Design, participants and setting

A mixed methods design was used as it provides insight and understanding into complex issues where further in-depth knowledge is required.[14,15] Mixed method research is regarded as a new paradigm which builds on triangulation between rather than within methods.[16] This innovative approach allows researchers the opportunity to utilise qualitative and quantitative research to provide a more comprehensive overview and understanding of a phenomenon.[16] By utilising this methodology we were able to provide a more informative, complete and balanced overview of the new MGP service.

The study was conducted between July 2013 and June 2014 at the sole tertiary public maternity hospital in WA which has approximately 6000 births annually. All MGP women attending the new service, who birthed a live baby were included. Ethical approval from the study hospital was granted for evaluation of the women and babies' outcomes (607QK) and the women's experiences (614QK).

Models of care offered at the hospital included: shared care (care shared between midwives, obstetricians and allied health); obstetric care (where obstetricians are the primary providers and midwives the secondary providers); Family Birth Centre (FBC) care (where midwives are the primary providers for low risk women, unless they become high risk, when they are transferred to obstetric care); and the new MGP. Both the FBC and MGP operate their services (antenatal, intrapartum and postnatal care) from a separate building within the hospital grounds. In the new MGP model, individual midwives are the primary providers for low risk women. However, if the women's risk status changed (such as being diagnosed with gestational diabetes or pregnancy induced hypertension) requiring obstetric care in the main hospital, the midwife continued to accompany the woman at every episode of care, representing a 'no exit' MGP. This meant midwives working within the MGP were able to provide continuity of care 24 h a day across hospital settings, throughout pregnancy, birth and first five days post birth, even if a complication occurred. The study was performed during the inaugural year of the MGP with seven midwives being employed, each midwife having a personal caseload of between 32 and 40 women, dependent upon their contracted hours. Midwives were employed on an annualised salary and had flexible days, allocated 24 h on-call days and rostered days off. Women were allocated a primary midwife at their first booking visit in pregnancy. They were subsequently introduced to a secondary midwife (during a morning tea), from the remaining team of six, who provided midwifery care if the primary midwife was on rostered days off, or caring for another woman.

2.2. Recruitment and data collection

2.2.1. Phase one

This prospective cohort study utilised three questionnaires (antenatal, intrapartum and postpartum) designed for the primary midwives to record the detail of each woman's journey as they received care, in the first year of the new 'no exit' MGP model. This enabled the midwives responsible for the women's care to accurately record episodes of care as they occurred. Questionnaires were designed in collaboration with the seven MGP midwives and piloted with ten women. Piloting highlighted errors in relation to the ordering of questions and the need for inclusion of additional data in relation communication with the midwife. Questionnaires enabled midwives to record the women's characteristics including: which clinicians provided antenatal care; where the care was provided; and the number of telephone contacts and text messages per woman. Obstetric outcomes included: gestation at the first booking appointment; antenatal admission requiring an overnight stay at the main hospital; whether the woman had a spontaneous onset of labour or was induced; pain relief received intrapartum; fetal monitoring intrapartum; length of labour; birth mode; third

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