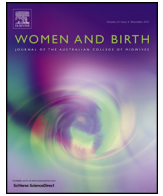




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### ORIGINAL RESEARCH – QUANTITATIVE

# Implementing caseload midwifery: Exploring the views of maternity managers in Australia – A national cross-sectional survey

Kate Dawson<sup>a,b,\*</sup>, Helen McLachlan<sup>a,b</sup>, Michelle Newton<sup>a,b</sup>, Della Forster<sup>b,c</sup>

<sup>a</sup>School of Nursing and Midwifery La Trobe University, Bundoora 3086, Australia

<sup>b</sup>Judith Lumley Centre, La Trobe University, 215 Franklin St, Melbourne 3000, Australia

<sup>c</sup>The Royal Women's Hospital, 20 Flemington Road, Parkville 3052, Australia

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#### ABSTRACT

**Background:** The benefits of caseload midwifery care are clearly documented, and many policy documents in Australia support its expansion. Despite this, little is known about the availability of caseload across Australia, nor about what proportion of women have access to a caseload model. This paper describes caseload midwifery in the public maternity system in Australia; its prevalence, and factors associated with implementation and sustainability.

**Methods:** A cross-sectional online survey of maternity managers of public hospitals that provide birthing services throughout Australia.

**Findings:** Sixty-three percent (149/235) of eligible participants responded. Respondents were from all states and territories, metropolitan, regional and remote areas, and from hospitals with very small to very large birth numbers. Only 31% reported that their hospital offers caseload midwifery, and an estimated eight percent of women received caseload care at the time of the survey, most of whom were considered to be of 'low obstetric risk'. Many respondents were planning to implement or expand caseload. Key factors associated with the implementation of caseload were funding to establish the model, the interest and availability of staff to work in the model, organisational support and perceived consumer demand.

**Conclusion:** This is the first study to explore caseload implementation at a national level. Although the number of services offering caseload midwifery care has increased nationally, access remains relatively limited. Women who live in metropolitan areas and who are considered at 'low obstetric risk' are most likely to be able to access this model. Funding and support for establishing new models are the main barriers to implementation.

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#### Summary of relevance:

##### Problem

Little is known about the availability of caseload across Australia and the enablers and barriers to its further introduction and expansion.

##### What is already known

The many benefits of providing caseload midwifery care are clearly documented, and many policy documents in Australia support its expansion.

##### What this paper adds

This paper provides a snapshot of caseload midwifery in the public maternity system in Australia, including its prevalence, factors associated with its implementation and sustainability, and potential factors that enable or hinder implementation of the caseload model.

#### 1. Background

Maternity care policies in Australia recommend providing women with continuity of care for pregnancy and birth.<sup>1–5</sup> These policies reflect the large body of evidence that has demonstrated

\* Corresponding author at: Judith Lumley Centre, La Trobe University, 215 Franklin St, Melbourne 3000, Australia. Tel.: +61 03 9479 2203.  
E-mail address: [k.dawson@latrobe.edu.au](mailto:k.dawson@latrobe.edu.au) (K. Dawson).

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that women who receive continuity of care have fewer childbirth interventions (e.g. caesarean section), increased satisfaction with care,<sup>6,7</sup> and in the context of caseload midwifery,<sup>7,8</sup> no evidence of adverse outcomes associated with providing caseload care to women, even among women of mixed obstetric risk.<sup>8</sup> Continuity of care incorporates models such as team midwifery and caseload midwifery. Caseload midwifery care (also known as Midwifery group practice (MGP), Know your midwife (KYM) and one to one midwifery) aims to provide women with care from a known midwife throughout pregnancy, labour, birth and into the postnatal period.

Given the evidence of improved outcomes for women, it is also important to consider staff views of this model of care. The literature discusses issues associated with caseload work including, burnout<sup>9,10</sup> and work life balance.<sup>9,11–15</sup> Conversely a recent Australian study found that midwives working in continuity of care models may benefit from caseload, with increased professional satisfaction and lower burnout scores when compared to their non-caseload colleagues.<sup>16</sup>

Despite the evidence of the benefits of continuity of care, access to this model of care is still limited.<sup>5</sup> Potential benefits of the caseload model are not limited only to improved clinical outcomes; it has also been suggested that caseload midwifery could assist in keeping smaller maternity services open in the rural and regional areas and possibly enable some maternity services that have closed to re-open.<sup>17,18</sup> However, there is limited information on the availability of caseload midwifery across Australia, and no studies were identified that have explored, at a national level, issues related to sustainability and potential expansion of the model.

A number of Australian reports describe factors that have contributed to the successful introduction of caseload programs.<sup>19–21</sup> Factors identified in relation to the sustainability of caseload include, engagement and support at all levels within the hospital/service; strong support from the community; key stakeholder engagement and support, including 'champions' who will drive implementation; a belief in woman-centred midwife-led care; support for midwives to be able to sustain autonomy and flexibility including occupational and personal support; clear boundaries within the model; adequate cover for extended leave; adequate remuneration; and a clear role for managers within this new way of working.<sup>19–21</sup>

Given the lack of national data, we conducted a study (ECO – Exploring Caseload midwifery in Australia) which explored the introduction, expansion and sustainability of caseload in Australia. The views of maternity managers, midwives, and midwifery students have been sought, and aspects explored included enablers and barriers to the implementation, expansion and sustainability of caseload midwifery, as well as an exploration of existing caseload models across the country, and how the models are configured. This paper presents data from one component of the ECO study; the survey of maternity managers. It aims to provide a snapshot of caseload midwifery in the public maternity system in Australia (where two thirds of maternity care is provided<sup>22</sup>), including its prevalence, factors associated with its implementation and sustainability, and potential factors that enable or hinder implementation of the caseload model.

## 2. Methods

This study used a cross-sectional survey design.

### 2.1. Participants

Public maternity hospitals in Australia were identified using the 'My Hospitals' website,<sup>23</sup> an Australian Government website

which provides information on public hospital services throughout Australia, and lists the number of admissions for childbirth at each hospital. 'My Hospitals' was searched in early March 2012 to determine which hospitals had births in 2011. Public hospitals which provided 'planned' birthing care to women were included, thus, hospitals with a maternity service but without a birthing service were excluded from the study, with the exception of one hospital that was reintroducing a birthing service through introduction of a caseload model. For hospitals with a low number of births (less than 50 as per the 'My Hospitals' site), phone contact was made to determine if there was actually a birthing service at the hospital, as very small birth numbers could have been the result of births occurring en-route to another hospital where the birth had been 'planned'. All eligible hospitals were contacted by phone to obtain the email details of the maternity manager, in order to invite them to participate.

### 2.2. Data collection tools

An online survey tool was developed specifically for the study, informed by the data tools and findings of a previous study of midwives' experiences of caseload.<sup>24</sup> The survey explored the characteristics of the hospital, existing models of midwifery-led care, respondents' views and intentions regarding caseload, and where caseload models already existed, the operation, structure and functioning of the models. The survey contained open- and closed-ended questions as well as Likert-type scales where respondents were required to select from a five-point response scale. Response options used were: 'Strongly agree', 'Agree', 'Neither agree nor disagree', 'Disagree', 'Strongly disagree'. The survey was designed to have embedded skips, enabling the completion of the survey to be responsive to certain questions about caseload, thus enabling appropriate questions to hospitals with or without that model.

Four rounds of piloting of the survey were undertaken with researchers, midwifery academics and midwifery managers within the research team's professional network. Changes were made following each round of piloting, then the survey finalised.

The survey was distributed by an email with an embedded link to Survey Monkey.<sup>25</sup> The email was sent to maternity managers of the eligible public maternity hospitals between February and April 2013. Reminders were sent by email at two and four weeks following the initial invitation to participate. Return of the survey was considered consent to participate in the study.

### 2.3. Data management and analysis

Data were downloaded from Survey Monkey<sup>25</sup> into an Excel spreadsheet<sup>26</sup> and then transferred into STATA version 11.<sup>27</sup> Data cleaning included range and logic checks, and where possible inaccuracies that were identified were corrected. Descriptive analysis was undertaken and frequencies and proportions presented. Open-ended questions were analysed using content analysis.<sup>28</sup> The responses were coded then collapsed into categories and then into themes. Agreement on coding, categories and themes were undertaken by two of the authors. Ethics approval was granted by the institutional ethics committees, in September 2012.

## 3. Results

An overview of results is presented first, then the findings discussed in three sections; hospitals not intending to set up a

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