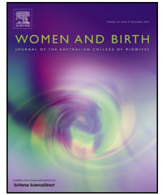
Women and Birth xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi



ORIGINAL RESEARCH – QUALITATIVE

Understanding the 'work' of caseload midwives: A mixed-methods exploration of two caseload midwifery models in Victoria, Australia

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ARTICLE INFO

Article history:
Received 25 June 2015
Received in revised form 25 October 2015
Accepted 26 October 2015

Keywords:
Midwifery
Caseload
Continuity of care
Midwives' experiences
Qualitative research

ABSTRACT

Background: Caseload midwifery models are becoming more common in Australian maternity care. Little is known about how caseload midwifery compares with mainstream models of midwifery care in terms of both the organisation of the work and the meaning of the work for caseload midwives.
Aim: To explore caseload and standard care midwives' views and experiences of midwifery work in two new caseload models in Victoria, Australia.
Methods: A mixed-methods approach was used. Quantitative data were collected using two cross-sectional surveys of midwives at the two study sites at the commencement of the caseload model and after two years. Qualitative data were collected using in-depth interviews with caseload midwives six months and two years after commencing in the role. Content analysis was used to analyse open-ended survey questions, and interview data were analysed thematically. Themes arising from these data sources were then considered using Normalization Process Theory.
Findings: Two themes emerged from the data. Caseload midwifery was a 'different' way of working, involving activity-based work, working on-call, fluid navigation between work and personal time and avoiding burnout. Working in caseload was also perceived by caseload midwives to be 'real' midwifery, facilitating relationships with women, and requiring responsibility, accountability, autonomy and legitimacy in their practice. Perceptions of caseload work were influenced by understanding these differences in caseload work compared to mainstream maternity care.
Conclusion: Increased understanding of the differences between caseload work and mainstream maternity models, and introducing opportunities to be exposed to caseload work may contribute to sustainability of caseload models.
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1. Introduction

Compared with standard models of care, caseload midwifery (continuity of care by a primary midwife) is associated with reduced childbirth interventions,[1–3] improved neonatal outcomes[1,2] and increased maternal satisfaction.[2,4] Given this evidence of benefit for women and infants, it is important to explore midwives' perspectives of working in a caseload model; a critical issue in terms of the sustainability and expansion of the model.

The majority of maternity care in Australia takes place within the hospital system where midwives work in shift-based staffing models. In contrast, in caseload midwifery, which is designed to facilitate care for women by a known midwife,[1,3,5] midwives work on-call rather than on a shift-based roster. Midwives have varying degrees of autonomy to organise their 'routine' work (e.g. antenatal and postnatal appointments) themselves, and the remainder of their time is spent on-call to enable attendance at labour and birth for the women in their caseload. Caseload midwives work in partnerships or small groups to enable care from a back-up midwife that the woman knows should her primary midwife be unavailable. In Australia, a full-time caseload midwife cares for 35–45 women per year as the primary midwife, and provides back-up for colleagues who usually have a similar caseload size.[5–10] There are industrial regulations that specify

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http://dx.doi.org/10.1016/j.wombi.2015.10.011
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conditions of work for caseload midwives, which vary from state to state. In Victoria the agreement stipulates that each caseload midwife is required to have a minimum of four clear days off each fortnight (regardless of their full-time or part-time employment status), and can work no more than 12 hours in any 24 hour period.[11]

While the benefits of midwifery-led continuity models for women and infants are well documented,[1,2,12] research needs to extend beyond clinical measures alone.[2,12] Newly introduced models of care may influence cost and resourcing of maternity services, and may also have an impact on the workforce in terms of recruitment and retention of midwives.[13] There have been calls for careful and systematic evaluation of the implementation of new models of midwifery care to examine the impact on midwives in both the short and long term,[12,14–17] with specific attention directed towards understanding the impact of primary midwifery-led models on midwives.[12] In 2008, two hospitals in Victoria, Australia that were introducing caseload midwifery provided the opportunity to explore the impact of the model from a workforce perspective.

1.1.1. Normalization Process Theory

Interventions such as the introduction of a new model of care are multi-faceted and often complex.[3,15,18,19] The caseload model has many 'ingredients',[15,20] and is a model of care that is embedded within health care systems, which in themselves are complex.[21] Normalization Process Theory (NPT) provides an approach that enables an exploration of the implementation and sustainability of complex interventions, because it recognises the roles of individuals and groups in the implementation processes[22–24] by focusing on the 'work' required to integrate and embed changes in practice.[22,25] NPT contains four constructs to understand the work of a new intervention: *coherence* (what is involved in the work of implementation), *cognitive participation* (who does the work required for the implementation), *collective action* (the operational work that is required to organise a new practice),and *reflexive monitoring* (formal and informal evaluations, and measures of outcomes associated with the new practice).[22]

We used NPT as a framework to explore issues relating to the implementation, acceptance and sustainability of the caseload model from a workforce perspective. Three themes emerged from the data. The first two related specifically to the work of midwives in the new model; caseload was a 'different' way of working, and the caseload midwives identified that the model allowed them to work in a way that was perceived by them as 'real' midwifery. The third theme related to how the organisations facilitated the implementation of the model. The aim of this paper is to describe the findings from the first two themes, which demonstrate how caseload compared and contrasted with midwifery work in mainstream models of care in terms of the organisation of the work, and the meaning and understanding of the work for caseload midwives. Findings regarding how organisations implemented the model will be reported separately.

2. Participants and methods

2.1. Setting

This study was conducted at two Australian hospitals that introduced caseload midwifery in 2008; the first, a tertiary facility located in metropolitan Melbourne with over 7000 births each year; and the second, a regional health service one hour outside of Melbourne with over 2000 births per year.

2.2. Design

A mixed-methods approach was identified as the most suitable for this study given that investigations of complex interventions are best addressed by research designs that combine qualitative and quantitative methodologies.[26] Quantitative data were collected using two cross-sectional surveys of all midwives working predominantly in the maternity services of the study sites; one administered at the commencement of the caseload model and the second after the model had been operating for two years. The surveys were designed specifically for the study and included questions on midwives' views and experiences of caseload, measures of burnout, measures of midwives' attitude to their role, and demographic questions. More detail on the survey tools is reported elsewhere.[10]

In-depth interviews were used to explore the views and experiences of caseload midwives in relation to the introduction, operation and sustainability of the caseload model at both sites. Interview guides were developed to explore the general themes around the change of the work that was involved in being a caseload midwife. The four constructs of NPT were incorporated in the interview questions to undertake a more in-depth exploration of how the work differs from standard midwifery 'work', the processes of implementation, and the functioning of the new model of care. Collaboration between the research team and the author of the NPT (Carl May) was instrumental in ensuring the topic areas in the interview accurately reflected the NPT while remaining meaningful to clinicians. Piloting of the interview questions was undertaken with caseload midwives who worked at hospitals that were not included in the study. Feedback on the clarity of the interview questions was provided directly to the researcher. No changes to the interview schedule were required after piloting.

2.3. Participants

The study involved caseload midwives (survey and interview), and midwives working in standard care models at the two organisations (survey only).

2.4. Recruitment

Standard care midwives were identified through payroll cost centres and included all permanent full and part-time midwifery staff working in midwifery roles at both sites. Return of the surveys was taken as consent from the standard care midwives.

All caseload midwives at the two sites were invited to participate in the study; written information about the study was provided before seeking written consent.[10] The different method for recruitment of caseload midwives was required due to the collection of data through identified surveys and in-depth interviews. All consented midwives at the first site who were in the initial caseload group were invited to participate in the interviews ($n = 10$). A further purposive sample of caseload midwives from the second site was selected to reflect a range of years of experience, full time/part time work and the different caseload groups, with the option of further sampling as needed if other areas of diversity were identified.

2.5. Data collection

The baseline survey of all midwives was distributed at site one in January 2008, and at site two in July 2008. Two years later the second survey was distributed (December 2009 and June 2010 respectively). Reminders were sent to participants two and four weeks after the initial survey distribution at both time points.

Please cite this article in press as: Newton MS, et al. Understanding the 'work' of caseload midwives: A mixed-methods exploration of two caseload midwifery models in Victoria, Australia. *Women Birth* (2015), http://dx.doi.org/10.1016/j.wombi.2015.10.011

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