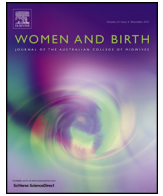




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Operationalising caseload midwifery in the Australian public maternity system: Findings from a national cross-sectional survey of maternity managers

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ABSTRACT

Background: Despite high-level evidence of the benefits of caseload midwifery for women and babies, little is known about specific practice arrangements, organisational barriers and facilitators, nor about workforce requirements of caseload. This paper explores how caseload models across Australia operate. **Methods:** A national cross-sectional, online survey of maternity managers in public maternity hospitals with birthing services was undertaken. Only services with a caseload model are included in the analysis. **Findings:** Of 253 eligible hospitals, 149 (63%) responded, of whom 44 (31%) had a caseload model. Operationalisation of caseload varied across the country. Most commonly, caseload midwives were required to work more than 0.5 EFT, have more than one year of experience and have the skills across the whole scope of practice. On average, midwives took a caseload of 35–40 women when full time, with reduced caseloads if caring for women at higher risk. Leave coverage was complex and often ad-hoc. Duration of home-based postnatal care varied and most commonly provided to six weeks. Women's access to caseload care was impacted by many factors with geographical location and obstetric risk being most common.

Conclusion: Introducing, managing and operationalising caseload midwifery care is complex. Factors which may affect the expansion and availability of the model are multi-faceted and include staffing and model inclusion guidelines. Coverage of leave is a factor which appears particularly challenging and needs more focus.

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Statement of significance

Problem or issue

Little is known about factors that influence the implementation and sustainability of caseload midwifery. How caseload is implemented, how it operates, and what influences the implementation, expansion and sustainability of the model requires further exploration.

What is already known

Caseload midwifery has benefits for women, their infants, and midwives.

What this paper adds

Australian national data from 43 public hospitals providing caseload midwifery shows how caseload midwifery is operationalised. It demonstrates the model's limited availability, especially for women of higher obstetric risk, the challenge of providing adequate leave coverage and complexity of implementation in diverse organisational settings.

1. Background

There is a strong body of evidence demonstrating the benefits of midwifery-led continuity of care for women and their babies.^{1–5} The Cochrane review, which included 10 team midwifery and four caseload midwifery trials, concluded that midwife-led care was associated with many benefits, including lower intervention rates,

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greater satisfaction with care, improved childbirth experience and improved infant health outcomes.³

Caseload midwifery care (also known as Midwifery group practice (MGP), Know your midwife (KYM) and one-to-one midwifery) is a model of care that aims to provide women with continuity of care from a known midwife throughout the antenatal, intrapartum and postnatal period.⁶ The caseload model requires midwives to work in a different way to traditional hospital-based midwifery roles, including working on-call, and managing their own caseload of women. Key principles for the sustainability of caseload relate directly to the work of the midwife within the model, and include midwives having the ability to develop meaningful relationships with women; have occupational autonomy and flexibility; support at home and work; and having a flexible model.^{7–10}

In Australia, a number of policy documents support and promote the increased availability of continuity of care models (including caseload) for women.^{11–15} Available literature suggests that individual health services may approach the implementation of new models of care to suit their own specific needs and requirements, and that models when implemented may need to go through various iterations of change both within the model and within the organisation.^{13,16–19} Caseload models function best when they are established carefully with both midwifery and management involvement,²⁰ are supported throughout the organisation, and when all staff (not only caseload midwives) understand the model.^{16,17,21}

Studies of caseload midwifery have been undertaken in a number of countries, including United Kingdom, New Zealand, Denmark, and Australia.^{1,2,20,22,23} However, comparing the operational aspects of caseload midwifery care in different settings and in different countries can be challenging.²⁴ Although many models are similar i.e. continuity of care from a known midwife (or backup) with a 24h on call component, delivery of the model is influenced by the different organisations and structures of maternity services in different settings. In the Australian context, caseload midwifery models of care have been operating for over 20 years²⁵ and availability of the model is increasing.²⁶ Although resources exist to guide organisations to establish caseload models,^{16,17,21} to date there has been little information regarding factors that may impact on the sustainability of the caseload model. Data reported to date has tended to focus on sustainability in terms of the midwifery workforce rather than the organisational perspective.^{27–29} Sustainability of the model is complex and may relate to many factors, including cost effectiveness, workforce interest and availability, and clinical outcomes. However, there is little evidence that brings these elements together.

Little is known about specific practice arrangements, barriers and facilitators at an organisational level, nor about the workforce required to operate a caseload model. This paper aims to address this gap by describing a range of operational aspects of caseload models across Australia.

2. Methods

We undertook a cross-sectional online survey of maternity managers of all Australian public hospitals that offered birthing services. Hospitals eligible to participate were those that provided 'planned' birthing care to women. 'My Hospitals',³⁰ an Australian Government website, was used to identify public hospitals in Australia with admissions for childbirth. This website was accessed in early March 2012 to ascertain which hospitals had recorded births in 2011. All hospitals were contacted by telephone to obtain email details of the maternity manager in order to send an invitation to participate. Where there were a low number of births (less than 50 per year), the phone conversation

also helped determine if a birthing service at the hospital still existed.

2.1. Data collection tools

The questionnaire specifically developed for this study was informed in part by findings of a previous study of midwives' experiences of caseload,¹⁹ and did not include any validated scales. The survey (hosted using an online platform³¹) explored the characteristics of each hospital; existing models of midwifery-led care; respondents' views of caseload; and the intention of the health service regarding the introduction, expansion and continuation of a caseload model. Open- and closed-ended questions as well as Likert-type scales where respondents were required to select from a five-point response option were used. Response options were: 'Strongly agree', 'Agree', 'Neither agree nor disagree', 'Disagree', 'Strongly disagree'. Embedded skips in the survey directed respondents to questions according to the availability (or not) of the caseload model in their organisation, or if there was an intention to implement the model.

Piloting of the survey was undertaken with researchers, midwifery academics and midwifery managers within the research team's professional network. Four rounds of piloting were conducted, with changes made as required following each round.

Dissemination of the invitation to participate in the survey was by email, with an embedded URL link to SurveyMonkey.³¹ The email was sent to maternity managers of all eligible public maternity hospitals throughout Australia. Completion of the survey was considered consent to participate in the study.

2.2. Data management and analysis

Data were downloaded from SurveyMonkey³¹ into an Excel spreadsheet³² and then transferred into STATA version 11³³ for analysis. Data cleaning included range and logic checks, and inaccuracies were identified and corrected (where possible). Descriptive analysis was undertaken and frequencies and proportions presented for closed-ended questions. Two items, (who should manage a caseload midwifery group, sick leave) were collapsed from the five item Likert-type scale into three responses; 'Agree', 'Neither', or 'Disagree', then the proportions compared. Denominators vary slightly according to the number of respondents to any given question.

Open-ended questions were analysed using content analysis. Content analysis involves quantifying content of qualitative data by systematically seeking out codes and categories within the data then recording and counting categories.³⁴ Open-ended responses in this survey were initially read in an inductive manner to establish codes, then the codes examined for similarities or differences and collapsed into categories. Further examination of the responses was conducted to tally the responses by category. Where quotes are used in the results, geographical location and annual number of births are presented to provide context to the comment. Responses to the open-ended questions were analysed and agreed upon by two authors.

Ethics approval was granted in September 2012 (FHEC number: FHEC12/149).

3. Results

3.1. Participating hospitals and availability of caseload

Of the 331 hospitals identified on the 'My Hospitals' website as having births in Australia in 2011, 79 did not provide a birthing service. Managers from the remaining 252 hospitals were invited

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