Exploring the key elements required for midwives to develop a new model of postnatal care within an acute care setting

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

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ABSTRACT

Aim

This research aimed to explore the key elements to improve the quality of postnatal care provided to women in a public hospital postnatal ward in Sydney and to attempt to implement a new model of postnatal care.

Background

Reports, internationally and nationally, indicate that women are least satisfied with hospital-based postnatal care when compared with antenatal, labour and birth care. Many researchers have identified the components of postnatal care that women find most helpful however, there continues to be barriers to develop and test innovative approaches or models of postnatal care within hospital settings.

The focus of this project was to try to move the postnatal ward to a culture that is woman and baby centred rather than illness or institution-centred. The development process drew on Practice Development approaches that would enable midwives to facilitate change in the environment and culture of the postnatal ward with a view to improving postnatal care for women and their families.

Method

A qualitative descriptive study, using a three phased approach, was adopted for this research. Phase one was to identify the issues and concerns by conducting focus groups with staff. Phase two challenged usual practices and explored new ways of providing care in the postnatal ward. This phase incorporated working with the staff utilising Practice Development approaches. The third phase explored with key stakeholders the outcomes and issues of phase two including the barriers and limitations to enable midwives to implement a new model of postnatal care.

Findings

There were a number of barriers for change to occur including the current system of maternity care provided to women. This has also been reported by others over the past few decades. Within an acute care hospital environment, the midwives struggled to provide quality midwifery care with a philosophy of care counter to that which had been imbedded over many years. Midwives were caught up managing the day to day issues and most were unable to reflect on the care women received or to have the time to contemplate changes.

Challenging the usual rituals and routines with the midwives generated some attainable changes that included providing women with more information about what to expect following birth and updated policies for healthy women and babies. The policies reflect the latest evidence and a more woman and baby centred approach to a daily assessment. This research also explored ways for midwives to be able to spend more time with women, and included challenging the everyday non-midwifery tasks undertaken by midwives working within the hospital system. These non-midwifery tasks included managing administration, security, catering and domestic duties.

Barriers towards providing a more woman and baby centred way of providing postnatal care included the need for further professional development of the midwives and more professional support. There was also a need for role modelling of woman-centred approaches to care and the development of a different way of providing care that included midwifery continuity of care.

Conclusion

Maternity services in hospitals have been subsumed into the general wards often governed by sickness priorities and it is acknowledged changing to a more woman-centred approach was challenging. Without support from leaders, the change towards a woman-centred approach may not happen within the constraints of the medicalised model.

Implications for Practice

My research found a number of implications for others planning improved postnatal care for women in an acute care setting. Key elements included the need for midwives to have a clear articulation of their vision for the ward. Change may not happen if midwives do not believe the benefits of providing individualised care that meets the needs of the women. For this to be realistic and achievable, strong visionary leadership is key to moving the ward vision forward and implementing a new model of care.

The timing for change in this setting is critical. It is unreasonable to implement change with midwives during a period of restructure. This can have a negative impact on successful change by threatening the midwives personal sense of control.

In summary, this research found that effective leadership, adopting a shared vision, providing high support and high challenge were all important elements to support moving towards a more woman-centred care approach. Threatening the midwives sense of control over their professional world was also found to be an important factor when attempting to bring about change and will be discussed in this thesis.

PROLOGUE

Motivations for the new role as researcher

Part of my new role as the clinical midwifery consultant in a busy metropolitan hospital's maternity unit was to develop midwifery models of care and support midwives to provide quality evidence-based care for women and their families. Whilst engaging with the midwives at the research site, I became aware of their frustrations. The midwives were concerned about the lack of quality of midwifery care they were providing the women.

I was, therefore, compelled to work with the midwives to explore the key strategies to develop a new model of care that met the needs of the women, the institution and the midwives. I commenced a Masters of Midwifery honours degree in 2008. My research journey of developing a new model of postnatal care is described in this thesis.

What I bring to this research project

I started my career in health as a nurse and later became a midwife. I have had a variety of experiences as nurse and midwife included being a manager, researcher and midwifery consultant.

In the 1980s I commenced midwifery hospital training and found similar hierarchical structure within the maternity system as I had experienced as a nurse in the general wards. During this period, technology was highly regarded. I was working in an environment where technology was thought to be superior to achieving better birth outcomes (Cragin & Powell-Kennedy 2006). At my training hospital, approximately 70% of women chose to have a private obstetrician and, as a consequence, many were subjected to unnecessary interventions. There were also limited opportunities for me to practise the art of midwifery and there were no opportunities to develop professional relationships with women within this medicalised system.

Working in this medicially dominated environment with limited support for the midwifery profession, I learned quickly, as a way of survival, not question rituals and routines. These traditional practices prevailed in an environment where midwives were disempowered to challenge practice. In the 1980s there were limited opportunities for midwives to provide midwifery continuity of care or be able to work in all areas of the maternity spectrum of care.

A turning point occurred following a conference I attended in the early 1990s in Sydney. The organisers of the conference explained their new team midwifery model of care by asking the midwives to describe the day in the life of a team midwife. These midwives were able to work autonomously, they were able to practice midwifery as defined by ACM (Australian College of Midwives 2006) and the care was focused on the woman rather than the institution.

As a midwife I am passionate about providing women with quality care, from midwives in respectful manner. The conference was a turning point in my career and ever since I have been actively involved in supporting midwives to move from medicalised models to midwifery models of care.

My bias towards the postnatal ward system

Childbirth a profound life event (Lavender & Walkinshaw 1998) and the experience should be powerful and rewarding, with care that focuses on placing the woman at the centre. My passion for woman-centred care and my feelings of frustration when women are not being provided with quality midwifery care undoubtedly influenced this research. Others have described this phenomena. For example, Patton (1990) describing fieldwork and observational research, identified that personal and professional experiences shape your view of the world which may influence the research process and outcomes. I, therefore, acknowledge that my professional experiences over the past 34 years in health, with the last 26 years as a midwife often providing midwifery continuity of care, have to some degree influenced this thesis.

CHAPTER ONE – INTRODUCTION

Postnatal care in a hospital-based maternity service begins after the birth of a woman's baby and continues up until approximately one week after birth. The main purposes of postnatal care includes ensuring the physical and psychological health of the woman, the establishment of breastfeeding, monitoring aspects of infant health and fostering the development of effective maternal-infant relationships (MacArthur 1999). Postnatal care is not the management of a condition or an acute situation (Demott et al. 2006). Despite the apparent simplicity of these purposes, the provision of adequate institutional postnatal care has been fraught with challenges.

The research reported in this thesis aimed to work with a group of midwives employed in a hospital-based postnatal setting to explore the key elements or characteristics deemed essential in the design of an innovative model of postnatal care. Postnatal care should be based on a wellness of primary health care model[1] and not an institutionalised acute care model of health. Postnatal care as in all aspects of maternity care, should positions the woman and baby at the centre of the care. For some time now, researchers and midwifery leaders have urged organisations and midwives to review current services and explore innovative ways to provide quality postnatal care in hospital-based maternity services.

This research reported in this thesis aimed to explore, with midwives working in an Australian public hospital postnatal ward in Sydney, the key elements of the service that would improve the quality of postnatal care provided to women and to design and implement a new model of postnatal care.

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[1] Primary Health Care incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health (Keleher, 2001).

Background to the Research

As the clinical midwifery consultant employed in the maternity unit at the research site, part of my role involved ensuring staff provided quality midwifery care for women and babies. Shortly after commencing employment in 2007, I met with midwives working on the postnatal ward to explore how they could improve the environment of the postnatal unit for the women and for themselves. This meeting was the catalyst for my research journey.

The midwives working on the postnatal ward said they were frustrated with the quality of midwifery care they provided to women. They felt they could not provide the care and support the women require to parent and breastfed well. They believed it was important for women to able to return home with confidence. Yet being able to spend more time with women to help with breastfeeding, talking about the birth and to discuss how they were feeling was challenging in the current acute care setting.

In the acute care setting midwives stated that they had to prioritise their workload according to the tasks required of them by the hospital, rather than providing care that was focused on women's needs. The midwives appeared unsure about how to go about change. Midwives need support to challenge the institutionalised ways of providing postnatal care. This includes questioning the rituals and routines associated with postnatal care such as fourth hourly observations for well women after a normal birth.

Many of the rituals and routines on the postnatal ward had developed over the past 50 years as postnatal care had moved into acute care hospital settings. The evolution of contemporary western hospital-based postnatal care can best be understood in the context of the historical influences on childbirth most particularly the medicalisation of childbirth.

Historical influences on childbirth

Until the 17th century, childbirth traditionally occurred in the privacy of the woman's own home. Childbirth was woman's business, a female 'mystery' (Donnison 1988) and considered a normal life event (Kirkham 1999). Midwifery was viewed as the work of local 'handywomen' (Bick, McCourt & Beake 2004, p. 1; Leap & Hunter 1993) who understood the everyday lives of the woman and her family (Page 2004).

During this time in Britain the living standards were poor (Barclay 2008; Donnison 1988), there was overcrowding and poor infrastructure including insufficient sanitation and clean water. Many people became sick with the spread of infectious diseases such as cholera and typhoid (Bick 2006a). Maternal and perinatal mortality and morbidity rates were high. It is likely that a similar situation existed in Australia.

In response to poor living standards and recognition of the need to improve access to clean water and appropriate sewerage systems, was the introduction of 'lying in' hospitals were introduced in the United Kingdom for the poor married women (Mackenzie 1827) with similar initiatives in Australia (Adcock et al. 1984). The establishment of the hospitals during this time represented a place where techno-medicine and a power base for medical doctors flourished (Dykes 2006a).

In 1818, in Sydney, Governor Macquarie built the first 'female factory' to address the concerns that the Benevolent Society had for the poor (Adcock et al. 1984, p. 24). The 'female factory' housed convict women for employment and punishments and also included the first maternity institution. Midwives were appointed for convict women. Free women in the colony gave birth to their babies in their homes with the assistance of a neighbour or friend, but rarely with the attendance of a midwife or a doctor (Adcock et al. 1984).

By 1848, the transportation of convicts to Australia came to an end and the 'female factories' were closed. Over the next 50 years in Sydney, a number of institutions were established where postnatal care occurred including the Benevolent Asylum Hospital

(which became the Royal Hospital for Women) in 1860, the lying-in hospital at Newtown in 1884, Crown Street Women's Hospital in 1897 and St Margaret's Hospital in 1894. This paralleled the development of maternity care offered to British women.

By 1890, there was a move to train more midwives and in 1900 hospitals were offering midwifery training schemes (Adcock et al. 1984). It was also during this time the lay midwives were provided training which also included domestic chores to support the postnatal woman (Marchant 2004). In Britain in 1902 the Midwives Act was implemented in response to inequalities of women and the need to improve health for all women in society (Marchant 2004).

These changes mean that women could have access to midwives and doctors for labour and in the time following birth. However, not enough was known about the spread of infection and the lying in hospitals were often grossly overcrowded. Instruments were reused unwashed, blood-soaked and contaminated. Linen was also reused and the high frequency of internal examinations led to increased infection rates, making these institutions 'places more of death than of life' (Marchant 2010, p. 8).

During the pioneering period in Australia women would hire 'The Ladies Monthly Nurse' who would stay with the woman in her home two weeks before the baby was due, assist with the birth, and stay for three weeks after the birth, allowing the woman to rest and recover (Adcock et al. 1984, p. 30). By the twentieth century women were monitored by midwives and doctors sometimes for a period of weeks after birth.

By the 1930s the Great Depression had begun across the world, producing a generation hardened by poverty and deprived of the security of a home. After the Second World War there was a population boom explained by soldiers were returning home, getting married, starting families, pursuing higher education and buying their first homes. In addition, displaced persons from overseas migrated to Australia and birth rates increased. The population boom had significant impact on the hospitals.

Maternity care increasingly took place in wards as part of busy hospitals with formally trained midwives and nurses providing care (Adcock et al. 1984).

A new era was emerging following the baby boom and included the invention of technology, education and government (Adcock et al. 1984). Women wanted to have their babies in hospital as they saw hospitals as safe and the perinatal mortality figures had improved dramatically, from 25 deaths per 1000 in the 1950s to 10.7 per 1000 in 1981 (Adcock et al. 1984). The reasons for this reduction included the introduction in the late 1930s of antibiotics and blood transfusion as well as improvements in neonatal resuscitation (Adcock et al. 1984; Loudon 1987).

During the twentieth century hospitals became overcrowded as society placed a great deal of confidence in the hospital institutions. As a result midwives working in the busy hospital postnatal ward environment had to increase their levels of efficiency to manage the greater volume of women and babies. In this situation, the midwives focus of care became routine, rigid and inflexible (Martell 2006). Midwifery was more aptly described in the 1960s as a specialty of obstetrics.

In the 1960s in industrialised countries, families and partners were not welcome to participate in maternity care as they were seen as carriers of infections. As a response, creating strict visiting hours were created and fathers were not encouraged to participate. The hospitals took over care of the babies, taking them from their mothers and nursing them in nurseries behind glass windows, only accessed by the staff (Martell 2006).

In the 1970s, with the strong influence of feminists ideas, women began to voice their concerns and demanded more control over their birth and postnatal care wanting to be involved in decision making Martell (2006). Women started to question the medical model, asking why their babies were taken from them, why their partners were not allowed to be with them during labour and birth, and why they required enemas and pubic shaving before giving birth. This was the beginning of a new era. Women

becoming active consumers rather than passive users and demanding control over their birth experiences (Martell 2006).

Postnatal care in the twenty first century

Childbirth interventions, including caesarean sections, have influenced postnatal care. The caesarean rate experienced by Australian women in 2007, was 30.9% (Commonwealth of Australia 2011) an increase of 10% over the previous decade (Australian Institute of Health and Welfare 2010). A high level of intervention in birth and subsequent surgical procedures (Tracy & Tracy 2003) has had significant ramifications for the delivery of postnatal care. Authors report the increasing intervention in childbirth particularly in relation to instrumental vaginal births and caesarean operations is associated with long term morbidity after childbirth (Glazener et al. 1998; Johanson, Newburn & Macfarlane 2002). Morbidity associated with caesarean section operations include risk of infection, sepsis, thrombo-embolism, haemorrhage and hysterectomy with babies having increased risks of respiratory distress resulting in an increase in admission to neonatal intensive care units (Grivell & Dodd 2010). As a result, the focus of modern maternity care is on risk reduction and is characterised by standardised procedures and routines, all aimed at efficiency and effectiveness (Cattrell et al. 2005; Newnham 2001). Addressing long term effects was not the focus of care. Many women experience physical problems following birth and if left undetected and untreated, women can experience chronic problems leading to impaired quality of life (Wilyman-Bugter & Tucker 2004).

Addressing women needs within hospital based postnatal care in the twenty first century is challenging as care is mostly provided in a fragmented way. Within the current system midwifery care is compartmentalised and the majority of women do not experience continuity of care. Moving from antenatal care to intrapartum then following birth she will be transferred to the postnatal ward where she will be met by another group of midwives.

In response to the dissatisfaction with the quality of postnatal care reported by women and by midwives, government reviews both nationally and internationally have recommended changes to maternity services (Commonwealth of Australia 1999, 2009; Demott et al. 2006; Department of Health Expert Maternity Group 1993a; Expert Maternity Group 1993; Health Department Victoria 1990; Maternity Services Advisory Committee 2000; NHMRC 1996; Roxon 2010). In Australia, these changes have included recognising the importance of a primary health care model and providing continuity of care and a woman-centred approach.

Postnatal care provided within contemporary maternity services internationally and across Australia, and has been dubbed the 'poor cousin' or 'Cinderella' of maternity services (Commonwealth of Australia 1999; Dykes 2005; Forster et al. 2007; Fraser & Cullen 2006; Homer et al. 2002; Wray 2006a) reflecting the poor status (Dykes 2009b). Because of relatively low mortality rates and the assumption of low maternal morbidity rates, (Dykes 2009b) postnatal care is under-valued is therefore often under resourced (Bick et al. 2011; Fraser & Cullen 2006). Midwives approach to postnatal care usually focuses on the immediate physical health needs of women after birth with little attention often paid to her psychological and social needs and preparing her to care for her infant and understanding longer term health issues (Gamble & Creedy 2009; Gilmour & Twining 2002).

Women often dissatisfied

Women describe the postnatal period as the least satisfying aspect of their maternity care experience compared to pregnancy and labour care (Cooke & Stacey 2003; Dykes 2005; Forster et al. 2006; Homer et al. 2002; McCourt et al. 2006; Renshaw et al. 2007). Women also report difficulties with breastfeeding, a lack of confidence in parenting and there is a high occurrence of postnatal distress and depression (Brown & Lumley, 1998; Thompson et al, 2002; Cooke & Stacey, 2003; Bick et al 2002).

The postnatal in-hospital length of stay has reduced dramatically over the past three decades (Brown et al. 2009; Forster et al. 2006) in response to budgetary constraints.

However the short time women are in the hospital postnatal wards limits opportunities to develop a midwife-mother relationship (Kirkham 2010b). These issues highlight the need for change to improve and provide effective postnatal care.

There have been a number of attempts to develop innovative approaches of postnatal care that address the dissatisfaction expressed by woman and midwives. The catalysts for change include woman's dissatisfaction as they experience physical problems following the birth of their baby, not able to gain confidence in caring for themselves or their baby and not having opportunities to develop a relationship with a midwife that provides continuity of carer[2]. In this context, midwives feel frustrated with the care they are providing as they struggle with the day to day issues working within the hospital institution.

In Australia, the Shearman report published over two decades ago (NSW Health Department 1989) identified the need to change the system of maternity care. This report recommended maternity services focus on woman friendly approaches to care and acknowledging the midwives role as underutilised and recommended woman have more access to midwifery care, implementation of more innovative and flexible approaches (Demott et al. 2006; Forster et al. 2005; MacArthur et al. 2003; McKellar, Pincombe & Henderson 2010; McLachlan et al. 2008; Schmied et al. 2009a; Yelland, Krastev & Brown 2009). Yet not much has changed and postnatal period continues to be neglected (Glazener, MacArthur & Garcia 1993).

Midwives often dissatisfied

Midwives have also reported being frustrated with the type of care they provided in hospital, (Beake et al. 2010; Bick et al. 2011) due to numerous reasons predominately the low levels of staffing (Forster et al. 2006) and shorter length of hospital stay (Brown et al. 2005) and as a consequence midwives report there was little time for

[2] Primary midwife provides the majority of the care throughout the early pregnancy to the end of the postnatal period. Continuity of carer sometimes named one to one midwifery or midwifery caseload practice (Homer, Brodie & Leap 2008).

helping women breastfeed and feel confident with mothering (Dykes 2005; Forster et al. 2007). There are limited opportunities for midwives to get to know the families better to enable them to make more careful assessments (Lindberg, Christensson & O¨hrling 2005). Midwives felt they were constantly struggle to provided the care they felt women need.

Implementing a new model

Numerous researchers and government reports suggest maternity care, within an acute care setting, should be based on the philosophy underpinning midwifery care that is, positioning the woman at the centre of care (Beake et al. 2010; Brown & Lumley 1998; Clare 1993; Commonwealth of Australia 1999; Demott et al. 2006; Homer, Brodie & Leap 2008; Kirkham 2010b; Page & Percival 2000; Pairman 2010; Stamp & Crowther 1994; Yelland, Krastev & Brown 2009).

The impetus for this research is based on a desire to move from a focus on the needs of the institution to a more woman centred care approach. It is argued that when the woman is positioned at the centre of care, the care will be individualised to her unique needs and situation. New approaches to maternity services should focus on promotion of self-care that is, women need to be supported in the decisions they make for themselves and their babies (Leap & Edwards 2006), and care should have a woman centred focus (Byrom & Gaudion 2010; Department of Health Expert Maternity Group 1993a).

To move from a focus on the institution to woman focused care Byrom and Gaudion (2010) explain midwives and care providers must strive to promote an empowering facilitative model of care. An example of this model is found when midwives are able to develop meaningful relationships with women. When midwives are able to work in continuity of care models they get to know women and their family. A level of continuity where relationships can be developed fosters increased communication and trust, which provides the woman and family with opportunities to discuss issues that are important to them with someone they know (Homer, Brodie & Leap 2008).

In contrast to midwifery continuity of care is the fragmented approach that is common in the hospital maternity units. Despite recommendations to move towards providing woman with continuity of care (Commonwealth of Australia 1999, 2011; Department of Health Expert Maternity Group 1993a; Health Department Victoria 1990; Homer, Brodie & Leap 2008; NSW Health Department 2000) there are numerous barriers, many of which will be articulated in this thesis. The study aim and objectives however, attempted to address these important areas and recommendations.

Study Aim

This research aimed to explore, with midwives working in an Australian public hospital postnatal ward in Sydney, the key elements of the service that would improve the quality of postnatal care provided to women and to design and implement a new model of postnatal care.

Study Objectives

The objectives of the research were to explore the following issues:

- Midwives' perceptions of quality postnatal care;
- Barriers to the delivery of quality postnatal care;
- Strategies that could be implemented to improve the quality of postnatal care and the working environment;
- The design of a new model of postnatal care based on the findings; and,
- Identify staff learning and development required to implement the new model of care.

Overview of study methods

A qualitative descriptive study, using a three phased approach, was adopted for this research. Phase one was to identify the issues and concerns by conducting focus groups with staff while phase two challenged usual practices and explored new ways of providing care. This phase incorporates the action component which included

working with the staff utilising Practice Development approaches. The third and final phase explored with key stakeholders the outcomes and issues of phase two including the barriers and limitations that enable midwives to implement a new model of postnatal care.

The research site has been de-identified throughout the thesis to protect the anonymity and confidentiality of the hospitals and the participants. The reference material pertaining to the research site is labelled 'De-identified', both in the text and in the Reference List.

Structure of the thesis

The thesis incorporates seven chapters as outlined below.

Chapter One provides an introduction and rationale for conducting the research as well as outlining broadly the issues and concerns regarding the current context of postnatal care. The evolution of contemporary western hospital-based postnatal care is also provided for the reader in this chapter.

Chapter Two provides the reader with a background of the history, the community and the culture at the research site. Included in this chapter is a description of the Area Health Service, population characteristics, clinical data and the Maternity Service at the research site.

In Chapter Three a review of the literature is presented. The literature review describes the discord within the current context of postnatal care in developed countries. Chapter Three describes in further detail barriers and challenges for midwives as they try to achieve their goal of woman centred postnatal midwifery care. The barriers and challenges to effective postnatal care include the medicalisation of childbirth, the short time women stay in hospital following the birth and postnatal care being seen as less important compared to the antenatal and intrapartum components of maternity care.

Chapter Four explains the research design and provides details of the design, ethical issues, data collection and analysis. The rationale for the type of method employed and background to the methodology are described.

Chapter Five describes the findings of the research. The chapter is divided into three sections, describing the three phases of the study. The first phase describes issues and barriers identified by the midwives to provide quality postnatal care and the second phase presents the variety of activities used to develop the model of care and to work towards implementation. The third phase explores with key stakeholders the outcomes from the Practice Development phase. The body of data includes focus groups with midwives pre implementation interviews with key stakeholders and post implementation interviews. Data from field notes taken during the study are interwoven into the results.

Chapter Six the discussion chapter will explain the main points from the findings which have been identified and consistent with others research, however some issues unique to the research site will be explained in this chapter. Limitations of the study and implications for practice are included in this chapter.

Chapter Seven, the final chapter, concludes the thesis. The chapter includes the implications for practice and recommendations for others concerned with embarking on a project to improve the environment and care for women in the busy postnatal ward. Utilising what was found in the research will inform others wanting to improve their working environment for women and their families.

CHAPTER TWO - THE RESEARCH SETTING

INTRODUCTION

A description of the context of care is essential for the reader to gain an understanding of the issues and challenges within the research setting, and is therefore provided in the following section. A description of the Area Health Service, population characteristics, clinical data and the maternity services are presented in this chapter. The Area Health Service has been 'de-identified' and the references reflect this decision. This was undertaken to protect the anonymity of the site and the staff.

The Area Health Service

The research presented in this thesis was conducted prior to the recommendations from the National Health reforms which were implemented in 2010. During the research project there were eight large Area Health Services within New South Wales.

The Area Health Service, on which this research is based, provided healthcare to 20% of the NSW population (De-identifed AHS 2009). Within this Area Health Service there were a total of eleven hospitals of which eight provided maternity care. The research was conducted at two of the eight maternity units. In April 2008, these two units amalgamated services, including the staff and eventually one was closed. This amalgamation will be further described as it had significant implications on the research.

Local Context

The setting for the research was initially conducted at two Sydney Hospitals in New South Wales. A local hospital, named Alexandra Hospital, a pseudonym for the purpose of de identification, was established in the 1890s. At newly built teaching hospital was completed in the 1970s (Sterling Hospital, also a pseudonym). Women accessing the research site were predominately public patients; therefore, all their expenses were covered under the Australian public health insurance system, Medicare.

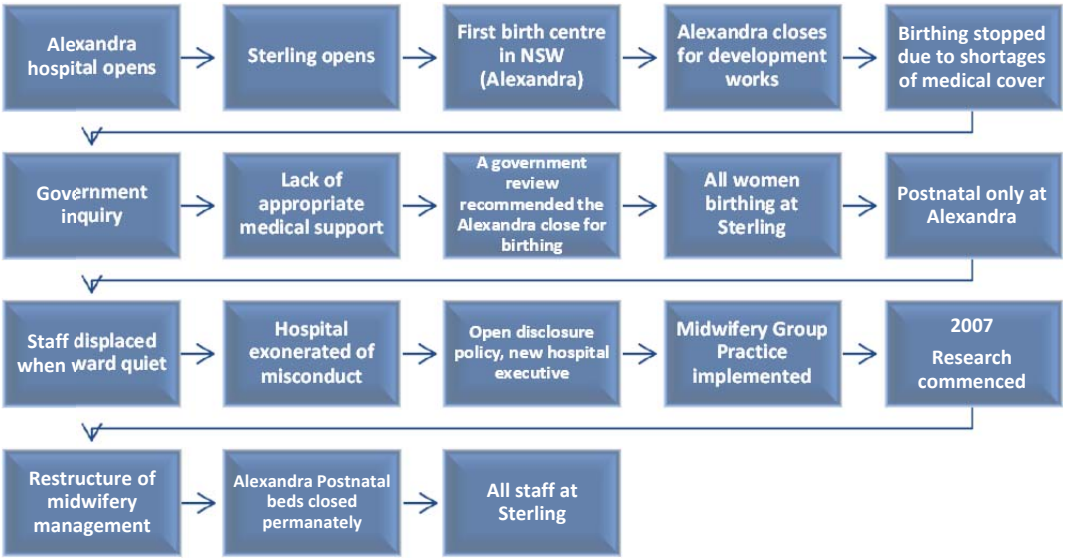
All intrapartum care[3] was conducted at Sterling Maternity Unit, as there were some safety concerns at Alexandra Maternity service due to a history of issues with medical support. Whilst many strategies were implemented none were sustained. Finally in 2005, following a government review of the services, Alexandra Maternity stopped providing intrapartum care. Women, locals and the midwives rallied in the main street protesting against the recommendations to close the unit for birthing. A subsequent government review recommended that a midwife–led unit[4] be implemented at Alexandra Maternity Unit. However, this model was not implemented (Maternity Services Advisory Committee 2000). Whilst birthing services did not return, two Midwifery Group Practices were developed and incorporated into the maternity services in 2006.

Whilst the implementation of the Midwifery Group Practices was welcomed by staff and women, more changes were about to occur. The amalgamation of the two maternity units created rumours of management and service restructure. These rumours created an atmosphere of distrust, upheaval and emotional turmoil amongst the women and the midwives, in particular those from the Alexandra Maternity Unit. Birthing services were never re-established at the Alexandra Maternity Unit and by 2010 the unit moved from an underutilised and relatively over staffed postnatal ward, to a much needed family day care facility.

To summarise a brief description of the history, including a timeframe of both Maternity Units is provided in Figure 1. These events were significant in shaping a culture that was resistant to future developments involving change.

[3] Intrapartum care – clinical care during labour and birth.
[4] Midwife-led unit – a model of care, usually free standing space/building in the community, midwives as the primary care providers for women without clinical risk factors.

Figure 1: Timeframe of the sequence of events at research site



To elaborate further on the research site, the characteristics of the people living in the area are discussed in more detail in the next section.

Population Characteristics

The Area Health Service was characterised by some of the most disadvantaged communities in NSW (Australian Government 2008b). The population characteristics of the Area health Service included the following features:

- Most disadvantaged community in NSW
- Increasing population rate
- More young single mothers
- Low rate of breastfeeding mothers

To gain insight into some of the challenges, which are unique to the research setting, these characteristics and their implications will be briefly discussed.

Most Disadvantaged Community

The people in this Area Health Service were amongst the most disadvantaged suburbs in metropolitan Sydney and New South Wales.

To demonstrate this point, the level of unemployment in the local government area was 7.5% compared to the Australian unemployment rate of 5.2% (Australian Government 2008a). This local government area also had the highest number of populace on pensions or welfare support including Disability Support Pensions, Newstart Allowance and Youth Allowance (De-identified Area Health Service 2006).

Increasing Population Rate

The overall growth was approximately 20,000 new births per annum in the Area Health Service, representing more than 22% of all births across NSW (NSW Department of Health 2010b). This trend has been projected to continue with young families expected to comprise a large proportion of new residential development. It was envisaged the influx of young families would increase the population by in the order of 250,000 - 300,000 people by 2030. This growth creates a demand for a considerable expansion in health service capacity (AHS 2007).

Also impacting on the increasing population, is the fertility rate of the women living in the area. The women in the research site had some of the highest fertility rates in the state. On average, the fertility rate across NSW was 1.81 births per woman. Women who lived near the smaller maternity unit, gave birth on average to 2.05 babies (De-identified AHS 2010).

Young Single Mothers

According to 'A Health Profile of Sydney South West' (De-identifed AHS 2005) there are more adolescent single mothers living in the Area Health Service. Pregnant adolescent women required specialised support and tailored service provision (Australian Institute of Health and Welfare 2010). Evidence indicates a greater potential for mental health issues, domestic violence and/or isolation for this group of women (De-identifed AHS

2005). Young single mothers can be a challenging group to work with due to the increased risk of adverse perinatal outcome, the long-term adverse effects on mother and child and the extra financial costs (van der Klis et al. 2002).

The poorer general health status of pregnant adolescents is confounded by inadequate antenatal care as they tend to book at a later gestation, attend fewer appointments or receive no antenatal care at all. Young women feel sceptical about health care providers as they can be judgmental. However inadequate antenatal care puts the woman at risk of low birth weight infants (Allen et al. 2011) and they experience higher rates of fetal and neonatal loss in spite of controlling for known confounders.

Clinical outcomes

An analysis of the outcomes for the babies of women accessing the services at the research site was undertaken. Outcomes, including prematurity and lower birth weight were compared with same level of maternity unit across the Sydney metropolitan area. In NSW, all maternity units are designated a level from 1-6 in relation to their resources and staffing. Level 6 is the highest, corresponding to a tertiary level referral service with a neonatal intensive care unit. Level 4 units can care for women with low to moderate risks and they have a special care baby nursery. The Sterling Maternity Unit was designated a Level 4 service.

Premature and lower birth weight babies

On average, more babies at the Sterling maternity unit were born prematurely that is, between 34 and 36 weeks gestation than in similar units. Over 5% of babies were born prematurely compared to other Level 4 units in NSW where the rate of prematurity ranged from 2.2% to 4.7% of all births (NSW Department of Health 2010b). This issue has implications for costing, resources, the community, the women and the staff, as these babies have higher service needs including admission to special care nursery. On average, these babies weighed less than other babies in comparable maternity units in Sydney metropolitan (NSW Department of Health 2010b). This group of babies requiring admission to special care nursery may have significant long-term illness

including disabilities and increase mortality rates (Australian Institute of Health and Welfare 2010). Prematurity and low birth weight are often also markers for social disadvantage.

Types of births

During the time of the research, 72% of women experienced normal vaginal births, 6% had assisted vaginal births that is, required instrumental delivery, and 22% had caesarean section operations (De-identifed AHS 2009). A comparison of birth outcomes with other women in NSW, the research site had above average normal birth rate compared with other Level 4 maternity units (NSW Department of Health 2010b).

Rate of Breastfeeding

The importance of breastfeeding has been well documented (Declaration 1990; National Health and Medical Research Council 2003; NSW Department of Health 2003; Thompson et al. 2002). Women accessing the services in this Area Health Services had the lowest rates of breastfeeding initiation in Sydney metropolitan area and the second lowest in NSW (NSW CPHN 2004). The state-wide Midwives Data Collection in 2008 found only 76% of women were breastfeeding their babies prior to discharge at the study site.

Maternity services amalgamation

As stated earlier, after years of uncertainly about the future of Alexandra Maternity Unit, in 2008 an amalgamation of both services was implemented. The midwives were deployed from Alexandra Maternity Unit to Sterling Maternity Unit creating much unrest with the staff from both units. In 2010, postnatal services officially ceased and the unit evolved into a much needed family day care centre. Table 1 provides the reader with a description of the combined services following the restructure and amalgamation of maternity units.

Table 1: The new Division of Women's Health - Maternity service capacity and functions

Service	Capacity
Bed numbers	
Antenatal and postnatal beds	24 beds
Birthing rooms	6 (plus 2 assessment beds)
Out patient services	
Antenatal clinics	Antenatal clinics including, 2 outreach clinics
Fetal Maternal Assessment Unit	√
Early Pregnancy Assessment Unit	√
Other services including:	
Midwifery Support Program (MSP) i.e. postnatal at Home	√ (50-60% of women)
Midwifery Group Practice	√ (10% of women including 70% MSP)
Pathology services	√ (limited) after hours
Ultrasound services	√
Medical cover	
Obstetric	√
Anaesthetic	√
Operating theatres	Limited (on call) after hours
Paediatric	√
Medical Emergency Team	√
Summary of births in 2008	
Total number	2680
Normal birth rate	1923 (72%)
Instrumental birth rate	162 (6%)
Caesarean section operations	577 (22%)
Average length of stay in hospital (days)	
Vaginal birth	2. 25
Caesarean operations	4.29

Philosophy of Care

Following the amalgamation and redesign of the management structure, the midwives employed at the Alexandra Maternity Unit were integrated into staffing within the postnatal ward at the Sterling Maternity Unit. Previously, there was much resistance from the Alexandra midwives to work at the postnatal ward at Sterling Maternity Unit. They found the environment of the postnatal ward challenging, as it was difficult for them to provide the care they had been providing women at Alexandra Maternity Unit.

The differences between the units were diverse and included:

- Different philosophies of care, medical versus midwifery, institutional versus woman centred;
- Differences in the socio-economic status of women accessing the services;
- Differences in the environment of the wards including increased noise and busyness at Sterling versus calm and quiet at Alexandria;
- Shorter length of stay in hospital after birth at Sterling; and,
- Lower job satisfaction amongst midwives at Sterling.

The women accessing the Alexandra Maternity Unit had less medical needs than women and babies at the busy Sterling Maternity Unit, therefore the midwives had been able to provide a more individualised care approach. Midwives preferred to work in the quiet ward of the Alexandra Maternity Unit rather than work in the busy task orientated unit and there was much resistance to move from this environment.

The amalgamation of the unit had a significant impact on the working relationships between midwives and the managers at both sites.

Staffing

The staffing profile of the maternity services included a total of 74.45 full time equivalents. There were 37 staff budgeted to work in postnatal services, only seven midwives were employed full-time and 30 were employed part-time. There were two part-time endorsed enrolled nurses who were employed to perform the hearing screening included in the budget for postnatal services.

The staffing each shift was usually comprised three staff members at Sterling for 24 beds and two midwives at Alexandra unit for 10 beds. The staff at the Sterling Unit had a ratio of one midwife to eight women and one to five at the Alexandra Unit.

Whilst not directly related to maternity services, a formal inquiry into complaints against the hospital had an impact on maternity staff. The inquiry, which occurred at the research site prior to the research, will be discussed in the next section.

Formal Inquiry into complaints

Prior to the research project, allegations of clinical negligence and malpractice at the hospital were made and a formal inquiry was conducted. At the time, the hospital service was experiencing many challenges due to the increase in demand for services over the past decade. Human and financial resources were stretched at all levels. Despite a major capital works program which included major upgrades at both hospitals, the service had great difficulty recruiting adequate numbers of appropriately qualified clinical staff (Government Inquiry [De-identified], 2003).

Following the inquiry there were many recommendations and changes to the existing hospital management and practices. There was a strong move towards open disclosure with quality and safety high on the agenda. The higher management structure recruited a new General Manager, Director of Medical Services, and a Director of Nursing and Midwifery.

Leadership and Management Structure

As a way to gain an understanding of local issues the newly appointed General Manager attended meetings at service level for each department across the hospital. Historically departmental meetings usually do not have high level executives attend meetings. This may have been a strategy of the General Manager to gain further understanding of the issues within the hospital or an example of a top down approach to management following the inquiry. The midwives employed in the Division of Women's Health were managed by the line manager who was directed by the Director of Nursing and Midwifery. The Director of Nursing and Midwifery also reported to the General Manager all issues relating to the nurses and midwives.

Following the amalgamation of services and the restructure of the Division of Women's Health in 2008, leadership included a Director of Obstetrics and Gynaecology with four staff specialists. There were three midwifery managers, each coordinated one specific area. There was an Antenatal Services Coordinator, Birthing Service Coordinator and a Postnatal Services Coordinator.

The roles of the midwifery managers included:

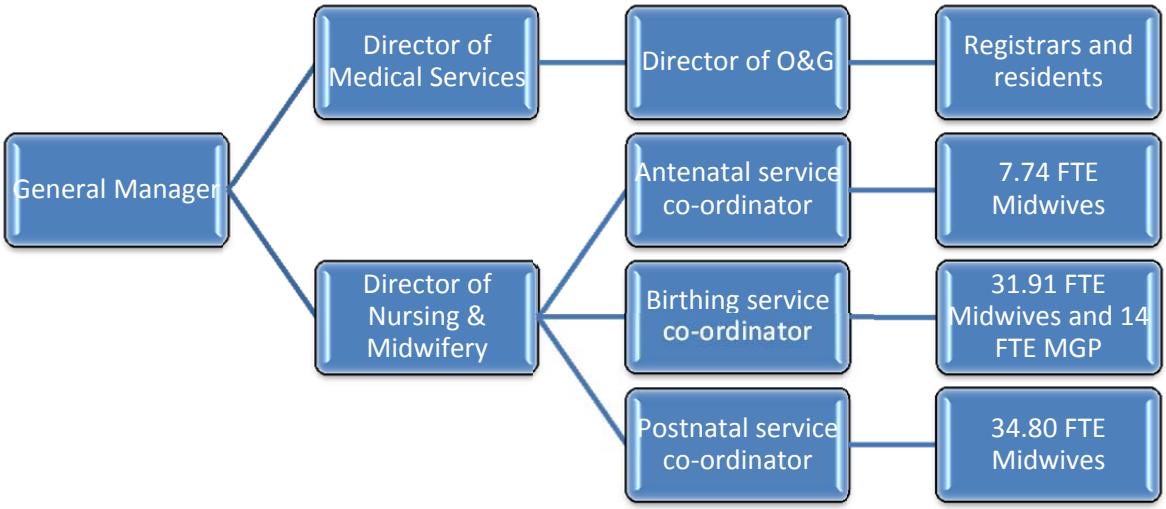
Antenatal manager: co-ordinated a variety of antenatal services for women accessing the service. Women could choose antenatal care at the Level 4 unit outreach clinics in community or at the antenatal services at the level one hospital, depending on risk factors.

Birthing manager: the manager organised labour and birthing care in the Level 4 Birthing Unit. Included in her role was providing leadership to the midwives employed in the Midwifery Group Practice.

Postnatal manager: The postnatal manager was in charge of the ward areas at the two sites that is, a total of thirty four beds. The role of the postnatal manager also includes managing the midwifery support at home program.

This structure is shown graphically (Figure 2) and includes the medical and midwifery responsibility including staffing levels in full time equivalent hours.

Figure 2: The management structure at the Sterling Hospital



Prior to the amalgamation of the two maternity units in 2008, the managers worked independently of each other. The manager of the Alexandra Maternity Unit had been responsible for all aspects of the Maternity services for many years and was accustomed to working relatively independently of the other hospital. Following the amalgamation however the Alexandra manager was required to move to the Sterling Unit and was responsible for antenatal services only. The rationale for the management restructure was to create a consistent management approach across the two sites by streamlining and combining the services.

By allocating one manager for each aspect of pregnancy care, it was envisaged each manager would have a high level of clinical expertise in one particular clinical area, provide consistency in all aspects of care, and therefore improve quality of care for the women. Working at the one site the managers were required to work together as a team relying on each other's skills and support.

The amalgamation and restructure occurred during the research project and created much change for all involved in the services particularly the midwives and managers.

This unsettling time impacted on the research results and findings and will be discussed further in the thesis.

CONCLUSION

The background and description of the research site is provided to gain an understanding of the context of postnatal care in the research site. In summary, the women accessing the service were younger and had more babies than other Australian women. The women had complex needs predominately in relation to social and psychological issues and were less likely to breastfeed their babies. The women gave birth to more babies prematurely and their babies weighed less than other babies at similar sites across the Sydney metropolitan area. Despite being classified as the most disadvantaged community, women experienced more normal births compared to other women in same level four role delineated services in Sydney.

The complexity of the service also included major changes involving leadership and management restructure. Closure of Alexandra Maternity Service and the staff having to be deployed to the busy institutionalised unit had impacted on the staff morale.

In summary, staff were dealing with top down approaches to change following a government inquiry. Strategies including open disclosure, being transparent and a feeling of being more accountable were instigated across the hospital. This may have caused staff to feel a loss of control as professionals over the care they provided and the approach to change may have made staff feel less valued or respected. These changes occurring previously and during the research project may have influenced the likelihood of change and innovation being successful.

CHAPTER THREE - LITERATURE REVIEW

INTRODUCTION

In this chapter, the literature related to contemporary postnatal care is reviewed. The aim of the literature review was to:

- Identify women's needs and concerns in the early postnatal period;
- Describe what is known about postnatal care in Australia and overseas from the perspective of women and midwives;
- Explore barriers to the provision of quality of hospital-based postnatal care; and,
- Identify exemplars of positive change or successes in improving the design and delivery of postnatal care.

A search of the relevant literature was initially conducted in 2008 and repeated in 2011 to identify new research relevant to both the literature review and the discussion. Two main strategies were employed. Firstly a search of the databases, MEDLINE, CINAHL, the Cochrane Library, PubMed, OVID, Medline, Informit, and Wiley Interscience Collection using the following key words: post-natal, postnatal, postnatal care, postpartum, breastfeeding, qualitative research, maternity, childbirth, midwifery, continuity of care. In addition, a web search of the relevant 'grey' literature was undertaken to identify key policy documents published by health departments in Australia.

The published studies identified through this search used a range of methods including large population-based cross sectional studies. These studies reported women's experiences and health outcomes. Other designs were randomised control trials and pre-test and post-test designs testing postnatal care interventions. Qualitative studies were also common, for example, using action research to introduce practice change, ethnography to study the culture of the postnatal unit and other approaches to study

the experiences of women and midwives. The literature addressed a range of topics and issues in postnatal care and is discussed below using the following headings:

- Women's physical and emotional health after birth, their experiences and reported needs in the postnatal period
- Midwives experiences of providing postnatal care
- Barriers to providing adequate postnatal care
- Approaches to new models of postnatal care

Women's physical and emotional health after birth

Studies in Australia and internationally, report a high level of physical and emotional health problems after childbirth (Bick & MacArthur 1994; Bossossian 2003; Brown & Lumley 1998; Glazener & MacArthur 2001; Thompson et al. 2002). What is evident is that childbirth is a major life event and the time taken for physical recovery can be much longer than thought and this can impact on more women than health professionals may have previously believed. Bick et al and others (Symon, MacKay & Ruta 2003) report that there is most likely a lack of accuracy of the prevalence of the health problems women encounter following birth, noting that women are often reluctant or embarrassed to report these problems and view them as part of the process of giving birth issues (Bick, MacArthur & Winter 2009). Brown and Lumley (1998) surveyed 1,336 women in 1994 in Victoria, Australia, to ascertain the prevalence of maternal health problems six months after birth (Brown & Lumley 1998). They found one or more health problems were reported by 94% of women including backache, urinary incontinence, perineal pain and extreme exhaustion. This survey was repeated in 2000 (Brown, Davey & Bruinsma 2005) with similar findings. A population-based cohort study conducted in the Australian Capital Territory collected data via surveys at four days postpartum, and at eight, 16 and 24 weeks postpartum to ascertain maternal health following birth (Thompson et al. 2002). A total of 1,295 women participated and 92% completed the study. The researchers found some health problems showed resolution between 8 and 24 weeks postpartum, such as: exhaustion (60–49%); backache (53–45%); bowel problems (37–17%); haemorrhoids (30–13%);

perineal pain (22–4%); urinary incontinence (19–11%). No significant changes occurred in the incidence of other factors such as sexual problems or depression over the six months. Primiparous women were more likely to report perineal pain and sexual problems than multiparous women. Women who had undergone instrumental births reported more perineal pain and sexual problems compared to those with unassisted births (Thompson et al. 2000).

Similarly in Sweden, Schytt, Lindmark and Waldenström (2005) reported that very few women (9% of primiparous and 11% of multiparous) experience no physical problems following birth. In this study only 13% of primiparous women and 12% of multiparous women reported having no problems 12 months following birth.

Tiredness, headache, neck, shoulder and low back pain were common problems at two months as well as one year after childbirth. At two months, pain from caesarean section, dyspareunia and haemorrhoids were frequent problems, whereas stress incontinence was often reported at one year. Schytt et al (2005) reported that some problems are more common in first time mothers such as sore nipples, dyspareunia, perineal pain and dysuria (Schytt, Lindmark & Waldenström 2005).

Symptoms common 12 months after birth included headache, neck and shoulder pain and low back pain. Surprisingly, despite the number of minor and some more major health problems following birth, the vast majority of Swedish women reported their overall health as good or very good. Low self-rated health was associated with symptoms that affected general physical functioning and wellbeing, such as tiredness, headache, musculoskeletal problems, mastitis, perineal pain, dysuria, stomachache and nausea. Complaints related to more specific situations, such as dyspareunia, constipation and stress incontinence were not associated with self-rated health.

A review of physical health problems after birth by (Cheng & Li 2008) found that across all studies reviewed, 15%–76% of the women experienced fatigue after childbirth, which could be the most frequent physical health condition experienced by postpartum women, and the condition persisted for 12 months for some women.

Many women also experience difficulties with breastfeeding in the early postnatal period, such as pain and nipple damage, inadequate milk supply and mastitis (Cooke & Stacey 2003). Some women have reported a lack of confidence in their parenting role and there is a high occurrence of parental stress, postnatal distress and depression in the short and long term after birth (Brown & Lumley 1998; Cooke & Stacey 2003; Dennis & Ross 2006; Thompson et al. 2002).

Emotional health after birth

The factors associated with depressive symptoms across these longitudinal studies include low socio-economic status, low social support, poor partner relationship and unwanted pregnancy. A history of prior depression or anxiety and the quality of the marital relationship had the strongest association with depression (Abbott & Williams 2006; Loxton & Lucke 2009; Mamun et al. 2009). Furthermore, researchers in the Maternal Health Study in Victoria found that at 12 months postpartum, 17% of women reported experiencing physical and/or emotional abuse in pregnancy, within the first year postpartum (9% emotional abuse, 5.4% both emotional and physical abuse and 2.2% physical abuse alone) (Gartland et al. 2011).

Around 16.1% of women reported experiencing depressive symptoms at some point in the first year after birth. In the Maternal Health Study, point prevalence rates of depressive symptoms were 8.8% at six months (an increase from 6.8% at 3 months) (Yelland, Sutherland & Brown 2010) and in Mater Study in Queensland, 7.8% of women reported three or more depressive symptoms at 6 months (King, Najman & Morrison 1990). In the Australian Longitudinal Study of Women's Health around 10% of women reported a diagnosis of postnatal depression (Loxton & Lucke 2009).

In this review it is also important to consider the impact that the birth experience may have on a women's health and well-being. A traumatic birth experience can have a severe impact on women and their families (Ayers 2004; Olde et al. 2006) and is associated with negative outcomes, such psychological and emotional distress and ongoing physical pain (Beck 2004; Creedy, Sochet & Horsfall 2000; Czarnocka & Slade

2000). There is increasing recognition in the literature that for some women traumatic birth can possibly leading to post-traumatic stress disorder (PTSD) (Ayers 2007; Beck 2004). Large population based studies from Australia and the United Kingdom indicated that between 1-6% of women will develop symptoms of PTSD following childbirth (Ayers & Pickering 2001; Creedy, Sochet & Horsfall 2000). Post-traumatic stress disorder related to childbirth occurs when a woman fears her life or the life of her baby is in jeopardy. It can be accompanied with fear, helplessness and terror. It is associated with a range of thoughts including vivid memories of the event, flashbacks, nightmares and irritability (Ayers 2004; Olde et al. 2006).

Given the significant and persistent level of health problems following birth, it is important to consider how postnatal care can support women's recovery from birth. The next section of this review will consider what women want from postnatal care.

Women's perceptions and experiences of in-hospital postnatal care

Many studies have identified what women want and require from their postnatal care. Overwhelmingly, women report that they value individualised attention and care from midwives and other staff who are compassionate, positive and friendly (McLachlan et al. 2007, 2008; Morse 2004; Rayner et al. 2008; Sayers & de Vries 2008; Schmied et al. 2008; Singh & Newburn 2000; Stamp & Crowther 1994; Thomson 1996; Yelland et al. 2007). Research conducted in the United Kingdom (Dykes 2006b) and in Australia (Fenwick et al. 2010; McKellar, Pincombe & Henderson 2006; McLachlan et al. 2007, 2008) has found the most important aspect of postnatal care is having a midwife sit and listen to a woman's needs and concerns, ensuring that she is at the centre of making decisions about her care and that of her baby. In a recent Australian longitudinal survey, researchers found that women need appropriate acknowledgement and support with an emphasis on maternal role development to facilitate their transition into motherhood (Emmanuel et al. 2011). Other researchers particularly emphasise the social and emotional support women require following the birth of their babies most particularly if they have had a complicated or traumatic birth (Gamble, Creedy et al. 2004; Gamble and Creedy 2009; Yelland, McLachlan et al. 2007).

It is rare however, that women report receiving individualised care where a midwife listens to their needs and concerns. In the research conducted by Brown and Lumley in the mid-1990s, only 40% of women rated postnatal care as very good (Brown & Lumley 1998) and these proportions did not increase in a repeat survey in 2000 (Brown, Davey & Bruinsma 2005). This research undertaken in Victoria indicated women were least satisfied with postnatal care compared to antenatal and intrapartum care (Brown, Davey & Bruinsma 2005). In more recent research conducted in Western Australia, women rated midwives ability to provide adequate emotional support after birth as poor (Fenwick et al. 2010). Women have also described the in-hospital environment as noisy, concerned about lack of privacy and constant interruptions and therefore not conducive to rest and recovery (Dykes 2006b, 2009b; Rayner et al. 2008; Schmied et al. 2009a). Brown et al (2005) has also reported that many women preferred to leave the hospital early.

Furthermore, women are dissatisfied with the way information is provided in the postnatal unit. Researchers report that the information provided to women is rarely individualised to women's specific concerns. A survey conducted in NSW (Cooke & Stacey 2003), found the majority of women stated that they needed individualised information. Instead midwives simply assumed to know what information women wanted and this was delivered in a didactic or standardised way.

Barriers to providing adequate postnatal care: The perceptions of midwives and others

There are now a number of studies that have examined midwives' experiences and concerns in relation to providing postnatal care within contemporary maternity care systems in Australia and overseas. Overall, these studies highlight the multifaceted nature of barriers to the provision of quality care in postnatal wards (McKellar, Pincombe & Henderson 2002) and the frustration that midwives feel in not being able to provide high quality postnatal care within the hospital setting. For example, Rayner et al (2008) report in Victoria and McKellar, Pincombe and Henderson (2002) in South Australia that midwives are dissatisfied with the amount of time they have to spend

one to one with women on the postnatal unit. It is argued that the lack of time to spend with women is due to the short length of hospital stay and inadequate staffing levels which result in busy and often chaotic environments where midwives become task-focused in order to get through the day's work (McKellar, Pincombe & Henderson 2009b). In addition, midwives report experiencing disruption in their work because of the continual flow and presence of visitors (McKellar, Pincombe & Henderson 2002; Rayner et al. 2008).

The key barriers reported by midwives are discussed further.

Length of hospital stay

In western countries the length of stay in hospital following birth has decreased significantly over the past four decades. In the 1950s, women experienced up to two weeks in hospital, however the length of stay has gradually reduced from 3-4 days in the 1990s and early 2000 (Brown, Davey & Bruinsma 2005; Brown et al. 2009). In 2007, the average maternal postnatal length of stay in hospital was 3.2 days (this data includes all types of births and women in private hospital) (NSW Department of Health 2010b). The average length of stay at the research site was 2.25 days for women who experienced uncomplicated birth and 4.29 days for women who underwent a caesarean operation (Midwives data collection data base 2009). This parallels postnatal care provided in other countries. In a Cochrane review published in 2009, researchers (Brown et al. 2009) reported the average length of stay in hospital in United States, Canada, Sweden and Australia to be about two days for a uncomplicated vaginal birth and longer if a woman had a caesarean section or other needs and also varied by medical insurance status (Commonwealth of Australia 1999; Brown, Bruinsma et al. 2004; Yelland, Krastev et al. 2007).

Notably, the short amount of time women spend in hospital and the related 'churn' of admissions and discharges, appears to severely limit midwives ability to spend adequate one to one time with women to address their individual needs (Lindberg, Christensson & O¨hrling 2005; Schmied et al. 2009a). Schmied et al (2009a) reported

that, on average, midwives spend no more than 5 to 10 minutes on each contact with a woman in the postnatal unit. In 2003, Stacey and Cooke observed that on average, a woman received one and a half hours of care from a midwife in a 24 hour period (Cooke & Stacey 2003).

The production line - Fragmentation approach of maternity care

Studies report there is constant pressure on midwives from management to efficiently discharge women as beds are required by other women from the birthing unit. In her critical ethnographic research, Dykes (2005) examined the encounters between midwives and postnatal women in two maternity units in the United Kingdom. Dykes and observed that midwives and other staff were working in a highly medicalised setting, 'racing against the clock' and feeling like they and the women are on 'a production line' (Dykes 2006b, p. 166). In order to achieve maximum efficiency in the bureaucratic structure of the hospital and maternity unit, Kirkham (2010a) explains that midwifery care has been compartmentalised into different sections (eg. antenatal care, birthing units, postnatal units). The result is fragmented care and it is almost impossible for women to come to know any one care provider. Stacey (2003) reported that in the postnatal period women can be cared for by up to 13 different care providers. From the perspective of both women and midwives, this fragmented organisation of care does not allow the midwife to develop a relationship with the women they care for (Lindberg, Christensson & O¨hrling 2005). Wray describes in the UK, midwives can only manage a pragmatic response aimed at standardisation of care, risk reduction and a focus on efficiency and effectiveness (Wray 2006b). McLachlan et al (2008) also report that midwives working in a hospital setting are limited by the requirements of documentation that reflect an acute illness model of care. Walsh (2011) and others (Fraser & Cullen 2006) have also questioned the daily ritual of 'top to toe' physical checks for the mother as well as the baby, despite the lack of evidence of effectiveness in improving outcomes.

Staffing and skill mix

Most studies report the inadequate level of staffing on postnatal units identifying particularly the level of skill mix and ratio of women to midwives and the need to consider the care of the baby as a particularly difficult issue to resolve (Forster, McLachlan, Yelland et al (2006). Workforce measurement tools have been suggested as one way to try and determine the most appropriate staffing levels for postnatal wards. Birthrate Plus is one such tool developed to measure individual maternity units workload patterns and case mix (Ball et al. 2003) to calculate skill mix and ratio of women to midwives in maternity settings. In 2012, Birthrate Plus was implemented in NSW but this was well after this research was undertaken.

Until services can address the barriers to providing appropriate skill mix and ratio of women to midwives, maternity services will continue to be challenged in providing adequate postnatal care. In an Australian study conducted in Victoria, (Forster et al. 2005; Rayner et al. 2008) found only 32% of maternity units did not employ non-midwives to staff their units. The Australian College of Midwives (ACMI 2006b), the peak professional body for midwives in the country, does not support the employment of non-midwives in maternity units, however this practice continues.

Requirements to complete non-midwifery tasks

In addition to inappropriate skill mix, studies also report that midwives are commonly asked to undertake non-midwifery duties. In research conducted in metropolitan NSW, Schmied et al (2008) reported that heavy administrative loads, for example discharge documentation, organising collaborative care plans, answering inquiries and bed management issues, posed a significant barrier to midwives finding time to sit and talk with women.

In an effort to address this issue, some maternity units have deliberately employed non-midwives to undertaken these tasks. In a multidimensional Delphi study, conducted in the Republic of Ireland, McKenna, Hasson and Smith (2002) reported the benefits of employing midwifery assistants to attend to non-midwifery tasks. This

strategy allowed midwives to have time to be with the woman, providing the care the woman needed while leaving the clerical, domestic, portering and restocking duties to other employees. The benefits of employing midwifery assistants to attend to non-midwifery tasks were explored with the midwives in my research as a way to enable midwives to provide care for women. However, more often than not, the non-midwives would be allocated postnatal women to care for under the supervision of midwives with their own 'patient load'.

Low status of postnatal care

Postnatal care has been described as the 'Cinderella' of maternity services and is in a comparatively low position within the 'techno-medical hierarchy'. On reflection of the current status of postnatal care in contrast to antenatal and intraparum care, there is an assumption that the postnatal period is a non-critical period and the end point of a woman's pregnancy journey. This time that women recover and resume their non-pregnant self has often been neglected. It has been articulated that the postnatal period is the beginning of the journey, as women embark on their adjustment to become a mother (Wray 2006a). Due to relatively low mortality rates compared to other areas of maternity care services, postnatal care is often undervalued (Fraser & Cullen 2006). Getting 'it right' in the antenatal and intrapartum period is considered more important, as most litigation occurs during antenatal and intrapartum period and therefore requires more resources.

The literature reviewed here is unanimous in stating that change is required in the delivery of postnatal care. (Forster et al. 2005) Forster et al (2005) reported on an extensive review of in-hospital postnatal care in Victoria, Australia. This review made numerous recommendations including the need for more flexible approaches to the current length of hospital stay including no restrictions to home visits. The review also addressed the physical environment, recommending improved facilities, access to more single rooms and the creation of communal spaces that are comfortable for women to relax and rest whilst on the ward. In relation to staffing researchers recommend increasing the staffing ratio of each one midwife for three to four women,

having flexibility within the current way rostering is done and implementing continuity of care options. Overall, they (Forster et al. 2005) suggested increasing the focus on woman-centred care to meet the individual needs of women. Wray (2006b) adds from her observational study, that the purpose of postnatal care needs to be very clearly articulated, successes need to be shared with colleagues and the organisation and its status raised if it is to remain as a domain of practice in midwifery.

New approaches to postnatal care

There have been a number of attempts to introduce new approaches or models of postnatal care dating back to the late 1980s when birth centres and 'early discharge programs' became popular. Traditionally in Australia 'early discharge' programs meant women left hospital within a specified number of days of birth (typically under 48 hours) and were mostly, but not always, supported by midwives in the home. Over time, such programs have been renamed (for example, domiciliary programs, Midwifery at home) to reflect the fact that women are not discharged from the service but rather that it is the place where care is provided that has changed. Increasingly, models of midwifery continuity of care are offering more community and home-based options of care for women.

The place of postnatal care

Following the Shearman report in 1989 in NSW, there was a sharp growth in the number of maternity units offering postnatal support programs in the home. While there has been debate over whether early discharge from hospital impacts on outcomes for women and their babies (Brown, Davey & Bruinsma 2005) there has been a commitment to providing support from midwives in the home following discharge from hospital. Researchers have observed that when midwifery care is provided in the woman's home, midwives more often provide individualised, woman-centred care that is informed by a belief in the normal physiology of childbirth and the postpartum period (Hunter 2004; McCourt et al. 2006). Researchers have also found women experiencing midwifery care in the home are more satisfied with their

postnatal care in comparison to those cared for in the hospital (Bick 2006b; Moon et al. 1999; Wray 2006b). Lock and Gibb (2003) report that women found that home offered stronger feelings of security and support.

Given the continued preference of many women for home-based postnatal care and the dissatisfaction with hospital-based care, researchers question why hospital is assumed to be the most appropriate place to provide postnatal care for healthy women and babies (Dykes 2005; Bick 2006; Wray 2006; Yelland, Krastev et al. 2007). Research in the United Kingdom, suggests the midwifery profession needs to reconsider the suitability of the hospital as the best place for postnatal care. Yet (McLachlan et al. 2008) argue that when resources are scarce, care at home is not prioritised.

Continuity of care

Models of midwife-led care or continuity of midwifery led care are known to have benefits for women. The systematic review of midwife-led care by Hatem et al (2008) demonstrated that women experience a high level of satisfaction. Further work however, is needed to determine the impact of midwifery continuity of care models on outcomes for mothers and infants in relation to breastfeeding, parenting self-efficacy and confidence, and levels of postnatal depression.

Re-designing components of postnatal care

In the early 2000s in Australia, a number of researchers conducted projects designed to address the concerns with postnatal care (McKellar, Pincombe & Henderson 2010; Schmied et al. 2009a; Yelland, Brown & Krastev 2003) and in the United Kingdom (Bick et al. 2011). In Victoria between 1999 and 2001, the Southern Health Service implemented a package or set of maternity enhancement strategies as a way to improving early postnatal care (Yelland, Brown & Krastev 2003). These multifaceted enhancement strategies included opportunities for women to plan for the postnatal period through discussion visits with midwives in the third trimester; the development of consumer written information focusing on the postnatal period and including

maternal health, baby care and sources of support and advice after discharge. Others strategies included supporting the midwives and offering creative rostering including rotation of midwifery staff across intrapartum and postnatal care involving the formation of teams, mentoring and professional development opportunities; midwife skill-enhancement programs, including communication skills training; the development of a hospital-based domiciliary service staffed by teams of midwives on rotation from labour and postnatal wards; and the development of evidence-based guidelines and protocols.

The formation of midwife teams to rotate between the labour ward, postnatal wards and domiciliary care required a major restructure to the organisation of the midwifery workforce, and proved to be a major undertaking for the health service (Yelland, Brown & Krastev 2003, p. 393). While improvements were modest, comparative analysis revealed a significant improvement in overall ratings of hospital postnatal care; the level of advice and support received in relation to discharge and going home; the sensitivity of caregivers; and the proportion of women receiving domiciliary care after discharge. The study also found women did not request more information when they returned home and information was provided by midwives in a more sensitive approach, suggesting that models that focus on a social model increases women's satisfaction with early postnatal care (Yelland, Krastev & Brown 2009).

To address concerns with hospital-based postnatal care, senior staff and researchers at a Sydney maternity unit implemented organisational and environmental changes intended to allow midwives to spend more time with women and to facilitate increased rest for women (Schmied et al. 2009a). Strategies included structuring care and administrative tasks so that midwives were able to provide each woman they cared for with an uninterrupted period (20 to 30 minutes) of individualised care, support and education. The allocation of this time was supported by the establishment of a breakfast and parenting room with an allocated midwife available to facilitate parent led discussions particularly in relation to infant feeding and parenting support and advice. These sessions occurred in a communal room, a space that provided

privacy. Meals were delivered to the room as a way to encourage a group of women to sit and talk whilst having their breakfast or lunch. Other strategies focused on reducing noise and the 'people' traffic in attempts to address chaotic, busy wards, including facilitating quiet times by dimming the lights, not entering the rooms until after breakfast time (Schmied et al. 2009a). While women demonstrated increased satisfaction with aspects of postnatal care, the pre-test, post-test comparison data did not demonstrate any improvement in outcomes for women in particular breastfeeding duration, knowledge of postnatal health problems or concerns (Schmied et al. 2009a). The authors have speculated that the lack of change may indicate that the 'intervention', specifically the increased amount of one to one uninterrupted time with a midwife was not rigorously implemented.

Provision of evidence-based information to women

The provision of information is usually seen as an essential element of postnatal care. McKellar, Pincombe and Henderson (2009a) conducted a three phase action research study intended to better prepare new parents for the early days and weeks at home with a new baby. A series of information resources were developed with input from parents, midwives and other staff including a father support worker to assist the transition to parenthood. Literature produced included a postnatal planner booklet, “Coming Ready or Not!”, a brochure for mothers, “Congratulations … You’re a Mother!” and informational postcards for fathers, “My Dad …”. Staff received training sessions in the use of the resources. However, in focus groups conducted with midwives in the postnatal unit following the implementation of the resources, many were unaware of the resources or had not used them. McKellar, Pincombe and Henderson (2009a) report that the possible barriers to implementation of the strategies included lack of ownership of the change, negativity towards change and more importantly potentially a grief reaction to the loss of traditional ways of providing care.

In the United Kingdom, Bick et al (2011) used a total quality management process to design and implement improvements in the delivery of postnatal care to better

prepare women for postnatal recovery and transfer home. The study team obtained perspectives from a wide range of stakeholders on the barriers and facilitators to effective postnatal care in hospital including those of the women. Changes implemented across the organisation included the piloting and introduction of new handheld records to prompt evidence based individualised care with emphasis on only undertaking routine physical observations and examinations after the first postnatal contact based on the women's individual needs. At the request of the clinical governance team, the new records included a Maternity Early Obstetric Warning Score (MEOWS) chart in line with the recommendation of the previous Confidential Enquiry in to Maternal Deaths. Hospital postnatal discharge routines were revised to include stays on delivery suite of up to three hours post vaginal birth to encourage skin-to-skin contact and initiation of breastfeeding. Postnatal discharge preparation commenced on delivery suite.

Following this initial work, information from a range of sources for parents on aspects of infant care were introduced onto the wards including daily infant bathing demonstrations organised by maternity support workers, a range of breastfeeding information including posters on the wards, a leaflet to introduce women to the postnatal ward. Changes to the processing and issuing of routine prescriptions for pain relief and other medication women would need to take home with them were also introduced. The authors reported that all the midwives who completed questionnaires to evaluate the outcome of the changes were aware of the revisions introduced. Two-thirds felt these were more appropriate to meet the women's physical and emotional health, information and support needs. Some midwives considered that the introduction of new maternal postnatal records increased their workload, mainly as a consequence of colleagues not completing documentation as required. It was also difficult for midwives to change practice from routine daily physical examinations of women to limit this to when the woman's situation called for it (Bick et al 2011).

Skill development in midwives

To effectively support women, midwives require good communication skills including the ability to listen to women, to use appropriate body language and to respond appropriately to women's concerns. Research with midwives in postnatal units suggests that further development of communication and listening skills is required (McLachlan et al. 2007, 2008; Schmied et al. 2009a). To build midwives' confidence in their skills in working effectively with women on a one to one basis as well as in groups, two studies included additional training for midwives in communication skills (Schmied et al. 2008; Yelland, Brown & Krastev 2003). The study in the UK conducted by Bick et al (2011) conducted 18 half day workshops attended by over 100 clinical staff. Mainly midwives and maternity support workers attended to discuss the planned changes to care systems and processes, to explain the new postnatal notes, explore the importance of effective communication and provide an opportunity for discussion.

Other strategies have included ‘debriefing’ as an intervention provided to women to provide them with an opportunity to talk about their birth experience. Randomised control trials have been equivocal about the efficacy of 'debriefing' following birth (Rowan, Bick & da Silva Bastos 2007). However others argue that women benefit from the opportunity to talk about their birth experience with a caring and sensitive midwife. To further support the importance of postnatal debriefing, in 2010 NSW Health mandated hospital policies must incorporate a postnatal visit to women whilst in hospital to discuss her childbirth experiences (NSW Department of Health 2010a).

CONCLUSION

Despite numerous recommendations over the past two decades to improve maternity care provided to women, little has changed, most particularly in relation to postnatal care. Many women experience physical and psychological health problems following the birth of their baby with limited appropriate support from health professionals to ameliorate these problems and concerns. Evidence suggests that women receiving

midwifery continuity of care have better outcomes including initiation of breastfeeding (Hatem et al. 2008).

Postnatal care within the hospital setting currently focuses on reduction of risk of perinatal mortality and morbidity following childbirth rather than focussing on recovery and return to normal health (Byrom & Gaudion 2010). Women often report being isolated when they leave the acute care setting, especially when social support has not been encouraged or facilitated. The literature reviewed here is unanimous in stating that change is required in the delivery of postnatal care. To individualise postnatal care, research suggests we must first explore the current structures within the organisations. As McLachlan describes, the constraints of 'nursing' style approach to care and documentation make it difficult to provide women with what they want and need. A major shift in thinking about the way postnatal care is offered to women in the hospital setting is required (McLachlan et al. 2008). Postnatal care is predominately the midwives' domain. However, due to many barriers midwives within the current maternity system appear unable to provide the care and support women need, particularly in relation to supporting women with issues in breastfeeding and transition to motherhood (Dykes 2005; Rayner et al. 2007; Rayner et al. 2008). This provides the key motivation to undertake this study. This study explored with midwives and key stakeholders the strategies that would enable the development and implementation of a new model of postnatal care. In particular, it aimed to identify the strategies required to implement a 'woman-centred' approach that improves continuity of care and increases flexible approaches to care, which benefit women.

The next chapter of this thesis will describe the research design and rationale for the methodology; as well provide an explanation of methods of data collection and analysis.

CHAPTER FOUR - RESEARCH DESIGN

INTRODUCTION

This research project used a qualitative research methodology (Sandelowski 1995). This was because my research involved working with a group of midwives to explore their approach of providing postnatal care within a hospital setting and to investigate whether a new model of postnatal care could evolve. Utilising a qualitative method was most appropriate as the research explored what was happening and sought to gain insights in a specific environment within a social group (Roberts & Taylor 1999). Qualitative research methodology is valid in this situation as the study endeavoured to uncover the nature of the midwives' world (Strauss & Corbin 1990).

AIM AND OBJECTIVES

This research aims to explore the key elements to improve the quality of postnatal care provided to women and to implement a new model of postnatal care.

The objectives of the research were to explore the following issues:

- The midwives' perceptions of quality postnatal care;
- The perceived and real barriers to the delivery of quality of postnatal care;
- Possible strategies that could be implemented to improve the quality of care and the working environment;
- The design of a new model of postnatal care; and,
- The professional development needs of the midwives that would be required to implement a new model of care.

This chapter describes the research approaches used and a description of the processes employed to collect and analyse the data.

DESIGN

A descriptive qualitative research methodology was used. Descriptive qualitative research enables researchers to examine participants' experiences, their interpretations and describe their world (Schneider et al. 2007). A qualitative research approach is commonly used by researchers as the issues the participants experience also concern the research practitioners, particularly related to human behaviours and performance (Strauss & Corbin 1990).

A descriptive qualitative research methodology was chosen as it enabled a description and exploration of the participants' experiences when exploring the current model of care and designing an alternative. A useful component of qualitative method is the flexibility that researchers are able to utilise. This study used a variety of flexible qualitative approaches incorporated in the data collection and analysis.

Mason (1998) explains that whilst it is ideal to be flexible in a multilayered social world, it is also important for the researcher to be systematic and rigorous ensuring the research is strategically conducted while remaining contextual. As Mason explains (1996), the researcher must incorporate self-reflexivity and should be constantly taking stock of their actions and roles within the research project. These aspects seemed to fit well with this study as they enabled ongoing engagement to occur.

Historically, there are three main leading methodologies in qualitative research in health. These are often described as grounded theory, ethnography and phenomenology. However there are others emerging, particularly in nursing and midwifery (Schneider et al. 2007). Whilst attending an International Council of Nurses Conference, Annells (2007) reported that descriptive and/or exploratory qualitative research was commonly used by nursing researchers. The rationale for using descriptive qualitative is described in the following section.

Qualitative Descriptive Research Design

Qualitative descriptive research designs are intended to focus on the meaning of an event in time, including its location within the past and prospectively towards the future (McKinlay 1998). These designs do not restrict the researcher to any one particular approach and authors advocate using a range of approaches to both collect and analyse the data. Sandelowski (2000, p. 337) suggests that qualitative descriptive designs usually are 'eclectic' and can include a combination of sampling and data collection, analysis and re-presentation techniques. My study collected data from numerous sources including focus groups, interviews, and opportunistic encounters with participants in the postnatal setting as well as the collection of my field notes written as reflective notes. This multiplicity of data collection techniques fits well with a descriptive qualitative design.

During the time this study was conducted, I was employed at the research site and I had regular access to the participants. In many examples of descriptive qualitative research, researchers are required to position themselves close to their data with minimal influence as they aim to uncover meaning or recognise themes and or patterns thus giving a description of experience (McKinlay 1998). The skills of a qualitative researcher include being able to step back and critically analyse the situation, to recognise and avoid preconceived bias, to obtain valid and reliable data and to be able to have the skills to think abstractly (Strauss & Corbin 1990). Despite these constraints, it was important in this study for me to be close to the setting and the participants as will be seen during the activities conducted through Practice Development work.

During this project I worked closely with the midwives both as a researcher and through my substantive role as the Clinical Midwifery Consultant[5]. These dual roles

[5] Clinical Midwife Consultant - In NSW, the Clinical Midwife Consultant (CMC) role is defined as having five domains: clinical service and consultancy, clinical leadership, research, education and clinical services planning, management. Working in close collaboration with a multi-disciplinary team, CMCs provide clinical leadership, support and advice to other services. As an advanced practice midwife with expert knowledge and skills, the CMC contributes to the decisions and debate within professional associations.

meant that I had a broad understanding of the context and their world and understood the importance of being respectful of their situation and context. The positive and negative impact of the placement of the researcher (that is insider or outsider) will be discussed later.

Practice Development framework

Initially I believed Action Research methodology, incorporating a Practice Development framework (McCormack, Manley & Garbett 2006), would be ideal for this project as both provide opportunities to engage with study participants in a consistent way. However, I soon discovered there were limitations in being able to engage participants with the required consistency using Action Research cycles. The difficulties experienced engaging with midwives impeded the momentum for any of the changes to occur. Whilst not solely using a Practice Development framework, this research drew on this approach to guide the process of engaging midwives in practice change and present the findings of the study.

As Brazil (2003) explains, both the midwifery and nursing professions are practice disciplines and ideally need to be researched in the social context. Brazil's research was conducted with mothers and nurses in a special care nursery setting where she attempted to bring about changes through a Practice Development framework. It was anticipated that my research, incorporating a Practice Development framework as Brazil and others have utilised, would assist the midwives working on the postnatal ward to move towards a more woman centred approach (McCormack, Manley & Garbett 2006).

McCormack et al., (2006) describes Practice Development as a continuous process to improve quality care with the focus centred on the 'patient'. For this focus to be achieved, the staff involved in providing the care usually require further development

of their skills, knowledge and attitudes (McCormack 2009). The Practice Development framework is not just about changing practice, it is about changing the culture and moving toward patient centred care (McCormack & McCance 2006). Given the midwifery philosophy of woman centred care, this framework seemed ideal.

Organisational change in the health care system is a complex, multilevel process (Kitson 2008). Practice Development provides a framework to challenge the historical ways of 'doing things' within health care provision (Walker 2003). It encourages practitioners to question the usual ways of practice rituals and routines. A Practice Development framework enables clinicians to transform the culture and context of care through enlightenment and emancipation involving the staff working within their situation rather than top-down policy initiatives (Bloor 2004; McCormack, Manley & Garbett 2006).

My study was designed to involve groups, that is, the midwives on the postnatal ward, to bring about change. In Practice Development, it is recognised that a productive group of people is more successful than an individual, as groups are better at problem solving. Groups have access to more information than individuals do, they can spot flaws and biases in each other's' thinking and then problem solve in a way that individuals may not consider (Galanes, Adams & Brillhart 2004). A successful group involves individuals being able to make contributions to the organisation and the society as a whole. Galanes, et al (2004) suggests people like to contribute collaboratively with each other and as a result develop feelings of self-worth. Clearly, these were important strategies to harness in my research.

Aligned within the Practice Development framework of patient centred care, underpinning the new postnatal model would be a 'woman-centred' approach. Based on findings in the literature, this shift in direction might focus on increasing:

- Women's parenting skills and confidence;
- Breastfeeding initiation and duration;
- Women's knowledge of physical and psychosocial problems; and,

- Professional satisfaction of midwives.

Inclusion and exclusion criteria

To be included in the study, participants needed to have an understanding of the culture and history of the unit. Therefore, the midwives employed within the maternity service at the research site were invited to participate. The local child and family health nurses were also invited as they had some affiliation with the postnatal ward and the women. Many of the child and family health nurses had previously worked as midwives in hospital wards. This group was included to provide another perspective to the research.

Other groups included were the midwives who worked in the maternity service in management and leadership roles, the research facilitation group including myself and the midwifery educators associated with the ward were considered important to include even though they did not work on the ward on a daily basis.

Participants

Undertaking qualitative research does not require a set sample size as with quantitative research and should be based on the rationale and purpose of the study (Whitehead & Annels 2007). A diverse number and range of participants were recruited to the study and contributed to a number of sources of data.

This study used convenience sampling with the participants being those who were working on the postnatal ward on the day the focus groups were conducted. Purposive sampling was used for one to one interviews. The participants for the interviews were those in senior positions within the maternity services.

Data collection methods

Qualitative data collection methods can be in many forms (Taylor & Bogdan 1998). This research incorporated focus groups, interviews, field notes and opportunistic encounters with participants, predominately in the meetings and workshops relating

to the postnatal project. A description and understanding of each is described in the following section.

Focus groups

Focus groups are an important tool in qualitative research as they help to explore research questions and understand a consensus view from a homogenous group of people (Banning 2005). A focus group includes a discussion usually conducted over one to two hours exploring and clarifying participants' issues and concerns. Focus groups have a flexible approach starting with a number of predetermined semi structured questions (Banning 2005). Further probing on participants' remarks is important to elicit further views from the group, to clarify and focus on the chance comment and explore further for additional views.

Despite the usefulness of focus groups, some have argued they are limited as they may not be able to explore core issues compared with one to one interviews (Nyamathi & Shuler 1990). Yet as O'Donnell, Lutfey, Marceau and McKinlay (2007) explained, focus groups gave their researchers access to an insider perspective, allowing direct communication with participants. They found that one of the benefits of focus groups was that they provided key information including a collective set of values, experiences and observations of the participants in a relatively short amount of time (O'Donnell et al. 2007). To be able to elicit information, Crang and Cook (2007) identified keys strategies for successful focus groups including that researchers should conduct focus groups with people of similar backgrounds with similar interests to gain new ideas and perspective.

Focus groups reveal to the researcher the world of the participants' everyday experiences (Nyamathi & Shuler 1990). A skilled facilitator can also elicit a candid portrayal of participants' perceptions that often do not emerge from other forms of inquiry. These issues emphasise the characteristics of useful focus groups and are the quality in which spontaneity and candour is achieved (Nyamathi & Shuler 1990). It was these reasons that focus groups were an ideal method to use in this study.

Ideally, the facilitator must have prior training in conducting focus groups and not 'learn as you go' (Whitehead & Annels 2007, p. 127). Responding to this comment, the focus groups conducted for this research were initially conducted with an experienced researcher. As a research student, I studied literature describing the skills required and further developed my skills observing the experienced researcher.

Semi structured questions were prepared prior to the focus groups as a way to start the discussion but also to enable flexibility; this strategy allows the researcher to adapt questioning. As Banning (2005) explains, using semi structured questions allows for a degree of latitude to talk around an issue as needed.

To ensure individual opinions are heard, the skills of the facilitator are important particularly when more dominant or active participants may persuade or influence the passive members of the group. The skills of the facilitator are therefore important to reduce any gate-keeping (Nyamathi & Shuler 1990; Whitehead & Annels 2007). Gaining a consensus during focus group that reflects the agreed view of the group is also a skill of the facilitator. As the focus group comes to a close, the facilitator summarises the main points for clarification and thank the participants for their support (Nyamathi & Shuler 1990).

A second method of data collection included interviews with key stakeholders. The rationale and understanding of the advantages and processes for conducting successful interviews are included in the next section.

Interviews

Interviews are the most common method for qualitative research data collection (Borbasi, Jackson & Wilkes 2005) and are considered a prime method of qualitative data collection (Whitehead & Annels 2007).

Interviews can be structured, semi-structured or unstructured (Whitehead & Annels 2007). This flexible approach allows the researcher freedom to ask questions as they arise and explore issues further. Even when utilising a structured technique, open-

ended questions can be adapted for deeper exploration. Open-ended, semi-structured interviews have a quality which allows the interview to take shape as it progresses (Mulhall 2003). This research incorporated preselected but flexible questions which were developed prior to interviews with key stakeholders.

To allow conversations to flow, Whitehead and Annels (2007) advise that researchers should create an environment conducive for a flow of dialogue. These strategies include addressing adequate space, reducing noise and ensuring comfort prior to the interview (Whitehead & Annels 2007). Consideration of the participants needs should also be considered prior to conducting an interview.

Interviews should be conducted at a time that best suits the participants so as not to impose on the generosity of the interviewee. The researcher must consider the participant's workload on the ward if conducting an interview in employed work time and should arrange for a colleague to handover care as required. Locating the interviews in a quiet office away from the ward is also ideal to minimise distraction. Whitehead and Annels (2007) also suggest having a sign on the door displaying the interview is in progress to avoid interruptions.

These are some strategies to support the participant's needs prior to conducting an interview. These strategies allow the participants to focus on the interview and not be disturbed by interruptions or concerns relating to workload. These suggestions and strategies were all taken into consideration and implemented in my study.

Whilst organising appropriate physical space is important, the skills of the researcher, including ways to elicit dialogue and interacting with the key stakeholders is essential. Borbasi, Jackson and Wilkes (2005) explain that there is an assumption that nurses (and midwives) will have good communication skills, that is, suggesting that they will be competent at conducting qualitative interviews. However this does not always hold true as qualitative interviewing requires specific skills. I was careful to receive additional training and mentoring to ensure that I have the appropriate skills to undertake the interviews.

As described, qualitative descriptive research utilises numerous forms of data collection. In addition to focus groups and interviews, field notes and data collected from opportunistic encounters occurred during the second phase of the research.

Field Notes

Some consider field notes to be the very essence of a study and emphasise writing detailed field notes. Others claim that field notes are an additional piece of data from becoming immersed in the culture (Mulhall 2003). Field notes are an important method of accurately capturing what happens in the field without notes, there may be a tendency to fabricate (Van Maanen 2011). Crang and Cook (2007), who are ethnographic researchers, suggest when conducting any type of research, the researcher should keep a diary throughout the process. To preserve and convey the data from field work, a description of the situations and events need to be recorded in detail (Silverman 2005).

The aim of field notes is to identify and process the interactions of the situation (Silverman 2005). By preserving the data by writing field notes the researcher is in a better position to analyse the issues (Silverman 2005). Field notes can help understand how the participants described a particular activity or event; elicit reasons why things happen and describe the concerns and barriers participants confront in their day to day work (Silverman 2005).

Field notes include explanations and summaries of the activities taking place during the research. They are also a reflective journal to note what was happening at the time and follow opportunistic encounters with the staff at the research site. This has been called ‘a running commentary to oneself and/or research team’ (Eisenhardt 1989, p. 538). Other forms of field notes can come from information from one’s own research community including meetings with university supervisors and fellow students. Crang and Cook (2007, p. 51) suggest ‘all these encounters can usefully be noted’.

In this research, my field notes were used during the analysis and assisted to elaborate on other forms of data. They were an important part of understanding and being able to describe the context and the processes.

In the next section, ethical issues including obtaining consent, confidentiality and privacy and recruitment of participants will be discussed. Data collection and data analysis will also be discussed.

ETHICAL ISSUES

Protecting participants from emotional harm is important when doing research involving people. Engaging with the participants in my study allowed me to be privy to some of their issues and concerns. Some participants may have felt threatened by possible change and be unwilling to engage. Therefore it was important to seek ethical approval prior to commencing the research. Identifying issues and strategies to avoid emotional harm was provided in the application to the human research ethics committees.

Ethical approval was successfully sought from both the Human Research Ethics Committee Area Health Service [2007-146] and University of Western Sydney (UWS) for the overarching project – *'A healthy start to life: The design and testing of a new model of postnatal care'*.

Ethical approval was also sought from Human Research Ethics Committee at the University of Technology Sydney. Approval was granted [UTS HREC reference number 2009-096] prior to commencement (see Appendix 1).

Important ethical considerations included:

- The process to obtain consent;
- Participants and recruitment;
- Protecting the participant's confidentiality and privacy; and,
- My position as a Clinical Midwifery Consultant and insider researcher

These will be discussed further in the following section.

Obtaining Consent

In order to recruit participants, promotional flyers were displayed in clinical areas. I was also able to personally invite the staff on duty the day the focus groups were organised. Whilst supportive of the project, some staff offered to cover the workload of the participants rather than participate themselves. This enabled the focus groups to be conducted without interruptions.

When researching human participants, consent is a necessary requirement to protect their rights and the rights of others in the setting (Burns & Grove 2005; Frankfort-Nachmias & Nachmias 1996). As a strategy to protect the rights of the participants, prior to beginning the focus groups, all participants were given information to ensure they had an understanding of both the proposed research and the implications of participation before giving their consent.

Verbal and written consent was gained from all participants at progressive stages throughout the project. Consent was also obtained from staff who were not necessarily working predominately in the postnatal ward setting but had a keen interest as they were involved in providing postnatal care. These included those working in the community, in midwifery group practice and in leadership and management roles who were keen to participate.

Contact details of the Area Health Services' ethics committee was provided on the information sheets should a staff member wish to seek further information or make a complaint. There were no instances of either of these options.

Protecting Confidentiality and Privacy

Ethical concerns regarding disclosure of information should be discussed with participants prior to data collection. Banning (Banning 2005) advises that issues of

either a sensitive or professional nature must be discussed. Participants need to be reassured that anonymity and confidentiality will be maintained.

To address confidentiality and privacy, de-identification of place and persons where the research took place was undertaken. To further protect participant's confidentiality and privacy, aspects of sensitive or personal nature revealed during interview or interaction remained confidential. No aspect of what was said by an individual was relayed to managers or others in the health service. Sensitive information that could personally affect others would not be reported or would be written in a generalised way so as not to identify one person directly and cause personal suffering. Protecting the participants and the institution was a priority, and so numerous strategies were adopted.

To ensure confidentiality, participants were asked not to use names during audio-taping. On occasions, the midwives referred to their colleagues by name. I rectified this lapse in confidentiality when transcribing the data. No other identifiers were used in the transcribed data or reports of the project findings which ensured participant confidentiality.

As a means to de-identify the organisation, the name of the hospital and the area health service is not included in this thesis or the Reference List. Presentations at conferences and workshop have adopted the same principles. The hospitals involved are referred to by pseudonyms as Sterling and Alexandra Maternity Units. At the time of data collection, the researcher asked the participants if they felt these strategies to de-identify individual participants and the organisations were adequate and the participants felt the method of de-identification had been addressed.

It seems evident that when undertaking participatory and collaborative research, such as in this study, it is difficult to maintain confidentiality as this type of research takes people on a journey. Participants are often unaware of what the research will uncover and therefore do not fully understand what they are consenting to (Williamson &

Prosser 2002). These issues were addressed with the UTS Human Research Ethics Committee (see Appendix 2).

Project Participants and Recruitment

All midwives employed in the maternity services at the research sites (Sterling and Alexandria Hospitals) and the community-based child and family health nurses were provided opportunities to participate in the project. Expressions of interest were circulated and displayed in the ward areas asking for volunteers to participate in both focus groups as well as the working group to develop the model of care.

An invitation via the manager of the child and family health nurses was provided to the child and family health nurses. As explained earlier, it was considered that the child and family health nurses could make valuable contributions to the project as many of this group had worked in the postnatal ward setting in the past and had a good understanding of the context of care.

In addition, staff who attended meetings and in-services were opportunistically invited to participate. Examples of the opportunistic episodes included open forums and other regular meetings where it was anticipated that the discussion would contribute to the design of the model of care. These episodes provided an opportunity for those who had not already agreed to participate in the research to have their voices heard. All participants were informed that the minutes or the researchers' field notes were used as data for this study. They were asked to provide consent, confirming and acknowledging that the activity would be used in data collection.

To communicate the progress and findings of the research, information and updates of any initiatives via written communications were available for all staff to read. For example, minutes from all meetings involving the postnatal project and activities that the staff were working on were displayed in the tea room in a separate folder. Presentations were provided to keep all the staff involved and up to date on any changes being planned.

The midwives were provided with opportunities to engage in the study through an invitation to offer their written comments or suggestions in the folders kept in the tearoom on the postnatal ward. This was seen as a way to communicate the progress and findings from the data collection, to keep all informed and to create a sense of ownership and participation to all staff on the ward.

Being an Insider Researcher

As the Clinical Midwifery Consultant at the research sites, I was aware there were pre−existing working relationships between myself and the participants. I recognised my leadership role could possibly influence the research as the participant may have felt I had a certain degree of power over the participants.

Qualitative research involves a close relationship between the researcher and the participants (Schneider et al. 2007). The researcher and persons being researched develop an interpersonal relationship during social research such as in this study (Mason 1998). The researcher may become a friend to some participants. They may confide in the researcher as they develop a relationship which is characterised by a high degree of trust and confidence.

The researcher-participant relationship that develops over time can provide ethical challenges for the researcher. The participants may feel they can trust the researcher and reveal data that may be difficult to reflect in the data analysis with anonymity. The data then becomes identifiable by the participants and therefore it is difficult for the researcher to maintain confidentiality when conducting this type of research.

Borbasi et al. (2005) suggest that when conducting research within the field of work, a researcher should ideally consider some of the practicalities and predicaments prior to commencing research. This strategy is an important approach and will facilitate methodological strength (Borbasi, Jackson & Wilkes 2005).

Being a midwife researcher I recognise that I have an understanding of the culture because it is my culture as well. I do not have to immerse myself in the field as I am

close to the participants as the Clinical Midwifery Consultant situated close by at the end of the corridor in the ward. This familiarity with the field benefits me as an insider researcher therefore I can fit into the research setting with ease as I understand the context within the participants' world.

Being an insider researcher, looking at social problems and exploring change, has the potential to be more effective than policy makers as an agency of change. Burn et al (2012a) from an observational study warned when using Practice Development approaches, the novice researcher must be aware of the ambiguous characteristics of insider researcher. Bloor (2004, p. 322) provides a table of the advantages and disadvantage of researching in a social setting which I found very useful to consider in the context of this study (Table 2).

Table 2: Advantages and disadvantage of researching in a social setting

ADVANTAGES	ALLEDGED DISADVANTAGES
Qualitative researchers can capitalise on field work relationships with practitioners to stimulate interest in their findings.	Assisting practitioners in improving service delivery may be viewed as conspiring with experts and against them.
The rich descriptions of everyday practice found in qualitative research allow practitioners to compare their own practices with those reported in the research.	Researchers should be silent on social problems having no basis for superior knowledge.
New practices can be adopted by research descriptions.	The total amount of successful changes in practice is frequently over estimated.
Ethnographies may even provide a partial model for a new outreach services.	Practitioner autonomy is limited, especially in the creation of new services.

As the Clinical Midwifery Consultant and the researcher, I acknowledge and identify that I was an insider researcher and acknowledge the benefits to the research which may include understanding:

- The rules and regulations of the institution

- The participants' personalities
- Clinical practices
- Culture and history

I acknowledge that I had a reasonably intimate knowledge of the participants' world, the ways things work and the social and professional relationships within the research setting. These included the recent government inquiry, limited access to professional development, top down approaches to management and the lack of visionary leadership (reference not supplied due to confidentiality).

In any study, the researcher must decide what to do with the data to maintain mutual respect between the research and the individuals. The National Health and Medical Research Council (2005) stipulates that researchers must maintain respect for the dignity and wellbeing of participants. In my study, maintaining a respectful relationship with the participants took precedence over the benefits of the research and on occasion I did not include sensitive information that may upset participants. I was sensitive to the level of skill knowledge and attitudes of midwives and worked with them to support professional development in a respectful manner while still undertaking the study.

I acknowledged that some midwives may work on a specific set day; therefore I resisted imposing or over-researching those particular midwives as this can be an unfair burden on those individuals. Also engaging with the same individuals may influence the data as they may not reflect the whole group's ideas. For these reasons, engaging and providing all midwives with opportunities to participate was very important. This was achieved by offering data collection sessions during the evening and night shifts. Practice Development activities were often arranged during paid time so the midwives were not disadvantaged and this strategy enabled them to be included and feel valued.

Acknowledging professional prejudice

I recognise and clarify possible prejudices that I have towards the traditional way postnatal care is provided at the research site. During my career, I have been able to provide women with improved ways of providing postnatal care that are more satisfying for women and for me as a midwife. These new ways of providing care provides continuity of care with a known midwife which enables a relationship to develop. In these models of care, a midwife provides care for an allocated number of women per year from the first booking in visit into the early postnatal period. I have previously worked in this type of a model described and have seen the benefits in working in this way. My bias is my frustrations of the way in which postnatal care was provided at the research site where I feel that the midwives are working in an institution-focused way rather than with a woman centred focus.

Personally, I feel frustrated with the style of care women receive particularity on the ward setting in its current form. However, identifying this issue allowed me to recognise possible problems and introduce strategies to overcome them.

DATA COLLECTION

The method of collecting the data and the rationale for utilising these methods of data collection will now be explained.

Whitehead and Annels (2007) believe interviewing participants is the most effective method in qualitative research. As described earlier, my research used focus groups and one to one interviews as two forms of data collection.

As a learning researcher, practising on participants is not ideal and Whitehead (2007) stipulates it is important to get the interviewing technique right prior to commencing the interview. Facilitating focus groups and interviews require certain skills and qualities of the interviewer. Whitehead (2007) recommends interviewers should be non-biased, inviting, allow all to have their say, well versed at posing probing questions and be able to paraphrase to ensure that data is not lost in the interpretation. Audio-

recording to ensure accurate data collection and also to provide inferences about what participants are saying is important.

The project adopted a variety of qualitative methods of data collection to identify the key strategies that enable midwives to design and implement a new model of postnatal care. Data was collected through focus groups, interviews, field notes and records of meetings (minutes) and workshops. The data collection occurred over a period of three years from 2007–2010 in three phases. The three phases included:

> **Phase one**: The first phase involved engaging with midwives working in a postnatal ward to explore their issues and barriers to providing women with the care they need. This was achieved by undertaking focus groups with midwives.
>
> **Phase two**: The second phase was to make some changes the midwives thought would make the environment more midwifery focused. This phase was based on a Practice Development framework.
>
> **Phase three**: The final phase was to evaluate the issues and challenges of the project. This was completed by interviews with key stakeholders.

Most non-midwives working in the postnatal ward were excluded as the focus was on midwives. The exception was one non-midwife, an Endorsed Enrolled Nurse[6], who had worked in the maternity unit for a long time and had a good understanding to the context of care and the issues.

The next section describes the various methods of data collection used in this project.

---

[6] Enrolled Nurses undertake an 18 – 24 month course at TAFE or related Health Facilities to achieve a Diploma in Enrolled Nursing. An Enrolled Nurse is a second level nurse who provides nursing care, working under the direction and supervision of a Registered Nurse/Midwife. The supervision may be direct or indirect according to the nature of the work delegated to the enrolled nurse. Endorsed Enrolled Nurses have completed further medication endorsement to their training (Nursing and Midwifery Office).

Demographic data

Demographic data was collected prior to each focus group and key stakeholder interviews as a way to describe the participants. The data included questions regarding age, years as a practising midwife, education level, other relevant qualifications, where they worked including the area of work, how long they had been working there and if they worked part-time or fulltime. The participants were also asked about attendance at professional development opportunities and if this was supported by their employer. The demographic data was collated by the researcher using Excel software and calculating means and frequencies.

Focus groups

As described earlier, midwives were invited to attend focus groups via a one page flyer advertising the focus groups dates and times. The flyers that were displayed in ward areas made it clear that participation was voluntary. The midwives were provided with an information sheet to read prior to commencement of the focus group and signed a consent form as described previously (see Appendix 3).

A total of 45 participants agreed to participate in the focus groups. From September 2007 until April 2008, six focus groups were conducted. In addition, a focus group was organised with the child and family health nursing team at the local community centre. There was an overwhelming response from the community child and family health nurses, many who had midwifery training. Twenty participants attended this session.

On average, each focus group took up to an hour to complete. Usually there were two facilitators conducting the focus groups including myself and my university supervisor. However, on two occasions there was only myself.

During the focus group sessions, one facilitator took notes of key points made by the group. These notes were presented to the participants on completion of the focus groups in order to validate interpretation. Focus groups were digitally audio-recorded with consent from the participants. To ensure all information remained confidential,

each transcript was examined and any identifying names or organisations were removed.

All data remained stored in a locked filing cabinet in my office and the recordings were destroyed after being transcribed and analysed. Direct quotes from the audio-recordings were used to illustrate the key points made by the group in the Findings chapter.

The purpose of the focus groups was to gain an understanding of the midwives' perceptions of the *goals of postnatal midwifery care*; to identify situations that make it *difficult to achieve the goals*; to determine how they can *facilitate change* in midwifery practice to improve the care provided to women and to find out what support they need to be able to do this.

As a way to initiate discussion in the focus group, five prompt questions were developed including:

- What do you see as the aims/priorities of postnatal care?
- What do you think woman what in postnatal care?
- What helps midwives provide quality care to women?
- What are the barriers to providing quality care to women?
- What would you see as an ideal model of postnatal care?

While focus groups are helpful in identifying issues within a group and can be used as a way to develop what it is the research needs to explore, interviews often provide an opportunity to have a more in-depth discussion. One to one interviews can elicit deeper issues identified from the focus groups (Schneider et al. 2007). In recognition of this, interviews with key stakeholders were conducted in the third phase of the research.

Interviews with key stakeholders

Key stakeholders recruited for interviews included midwives who would often relieve the midwifery manager of the postnatal ward for leave and were considered to be team leaders working predominately on the postnatal ward. Another group recruited included the managers of the wider maternity unit and the facilitators of the Practice Development phase of the project.

A total of nine key stakeholders were interviewed. These stakeholders were selected because they were in either a leadership or educative role or had been in such roles during the course of the project and had been involved in particular initiatives to facilitate change. One to one interviews were conducted face to face during a six week period in 2010 as part of Phase Three.

The individual participants were approached by the researcher and provided with a written information sheet. All those approached agreed to be interviewed, signed a consent form and completed information regarding their demographic data. Interviews were digitally audio-recorded with consent. Again, to ensure all information remained confidential, I examined each transcript and removed any identifying names or organisations.

Again, the data remain stored in a locked filing cabinet in my office and the recordings were destroyed after transcription and analysis. In a similar way to the focus group data, direct quotes from the audio recordings were used to illustrate the key points made by the key stakeholders.

Questions were developed by the researcher and university supervisor to identify from the key stakeholders their *perceptions of the services currently provided*; perceived *gaps in services and/or practice*; ideas for *improving services* and possible *barriers to change*. Five key questions to elicit this information included:

- From your perspective, what has been the aim of the postnatal project?

- From your perspective, what have been key strategies that have been implemented that have been successful?
- What did you see as your role in postnatal project?
- What did you see as the main barriers for change?
- How do you think change can happen?

The key prompts included clarification of the aim of the research, what changes had been successful and which had not. Further discussion was conducted to explore their explanations to the barriers for implementing changes in the postnatal ward setting. Organisational and managerial issues were also discussed. The interviews took between 30 and 60 minutes.

Minutes of Meetings

All formal minutes and notes taken during the research, project team meetings and other related forums such as staff meetings were used to describe the progress of the activities or strategies undertaken during the Practice Development phase. The minutes and notes following meetings are described as additional field notes that support events occurring throughout the research journey. The minutes provided a record of the decisions made, challenges that needed to be addressed and aid the development and core components of the new model of care.

A combination of interactions with midwives at work, in the tea room, at the desk, in workshops and meetings allowed me to understand their situation. As an 'insider and outsider' researcher I was able to build rapport with the midwives that enable me to obtain a deeper meaning of their world with all their issues and challenges.

Field Notes

Field notes were taken following focus groups and interviews, meetings relating to the research, workshops and professional development activities as a point of reminder during the data analysis phase. Field notes aid researchers to commit to memory data relating to major themes (Taylor & Bogdan 1998). The field notes are a supportive

method of data collection with the purpose of incorporating regular reflections on the events that occurred during the research. Following encounters I would reflect on any issues as a way to also expand beyond what was heard and seen. The field notes in my research were written in a chronological order as suggested by Patton (1990) therefore assisting in final analysis.

DATA ANALYSIS

Data from the focus groups and interviews were audio-taped and transcribed into a word document. Data from field notes were typed into a Word document. Minutes from the relevant meetings were already recorded in a Word document. The demographic data was collated using Excel software and means and frequencies were calculated. The qualitative data were analysed using content analysis.

Analysis

Content analysis is a systematic and comprehensive summary of the data (Wilkinson 2004). Content analysis is concerned with meanings, intentions, consequences, and context (Downe-Wamboldt 1992). Content analysis simply entails inspection of the data for recurrent instances, irrespective of the type of instance then systematically grouped together (Wilkinson 2004).

I undertook a preliminary descriptive analysis of the recordings from the focus groups in May-June 2010 and final data analysis was completed in February 2011. As a way to further analyse the data I became immersed in the data by repeatedly listening to the recordings to dissect the main points commonly occurring or emerging from the data.

The main points from all of the interviews were then transcribed into a Word document. To highlight the main points and issues direct quotes from the participants were used. The data from focus groups, interviews and field notes were analysed to reveal the key concepts and themes. Content analysis, by way of its meaning, explores and summarises the data (Sandelowski 2000). The time between the initial data collection in 2007 to 2010 when the analysis began required me to become immersed

in the data again. I read the transcripts again and re-listened to the audio tapes to identify the main points in the data. The main points identified from the predefined questions were grouped together into themes and those which were similar in content were grouped into sub themes or concepts.

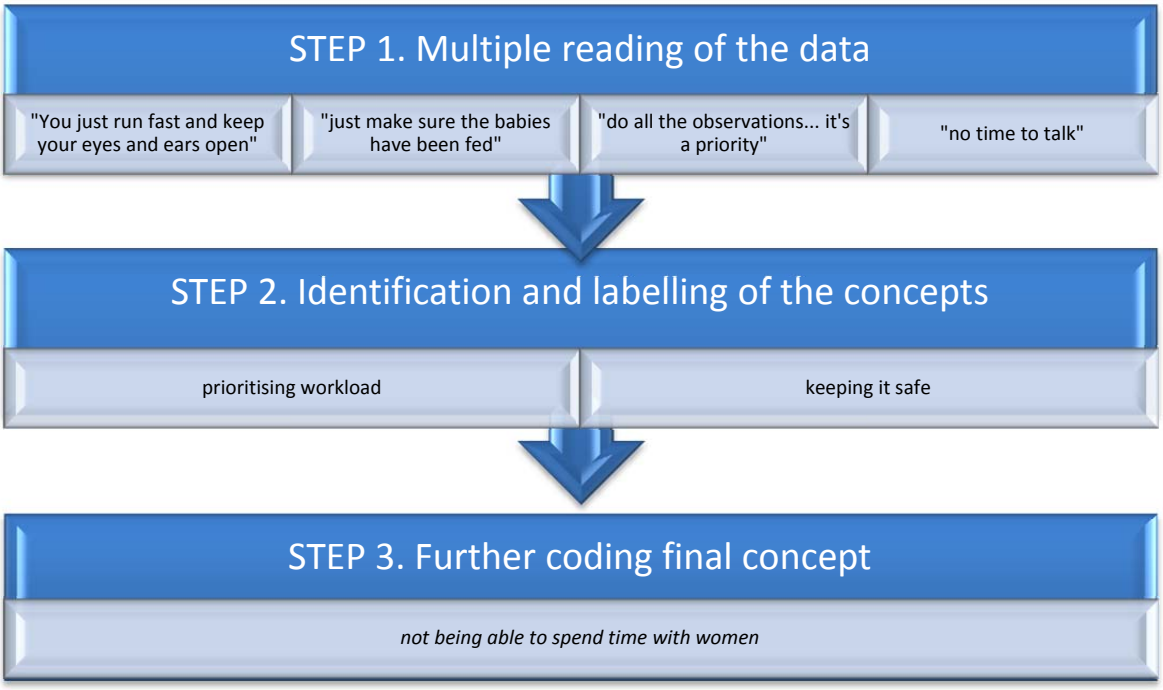
Themes that emerged from the participants' interviews were pieced together to form a comprehensive picture of their collective experience. When gathering sub-themes to obtain a comprehensive view of the information, it was possible to see a pattern emerging. When patterns emerge it is best to obtain feedback from the informants about them. Downe-Wamboldt (1992) suggests this can be done as the focus group or interview is taking place or by asking the informants to give feedback from the transcribed conversations at a later date.

The focus group data was also examined using content analysis in a similar manner. Data was broken down into components or concepts and then grouped into more abstract categories or themes. This is an iterative process where concepts, categories or themes and relationships with other categories or themes are constantly refined through the following steps:

- To become immersed in the data multiple readings of the data took place and listening to the recorded data was repeated;
- Identification and labelling of concepts in the data and development of preliminary themes or categories from these concepts, these are captured in phrases and were appropriate using the language of the participants; and,
- Further coding of the data in each theme, identification of linkages and relationships between themes (Liamputtong & Ezzy 2005).

These steps are further explained in Figure 3 below.

Figure 3: Steps taken to inform themes from the data



Validity of the process of data analysis

To enable validity of the process of data analysis the findings were checked with the participants in feedback sessions. Numerous sessions were presented back to the staff working on the postnatal ward for clarification of discussions from the multiple data sources as a method to authenticate the experiences of the participants (Downe-Wamboldt 1992).

Reflexivity

Qualitative research involves a close relationship between the researcher and the participants (Whitehead & Annels 2007). The researcher and persons being researched develop an interpersonal relationship during social research (Borbasi, Jackson & Wilkes 2005; Mason 1998). The researcher may become a friend to some participants and confide in the researcher as they develop a relationship. A relationship which is characterised by a high degree of trust and confidence that develops over time may challenge the researcher. To maintain mutual respect between the research and the

individual participants, the researcher must decide how to collect as well as what to do with the data.

Strategies to minimise disadvantages of being an insider researcher meant I was required to engage in reflexive practice. This meant I was required to critically examine and challenge my own assumptions and reflect upon my own experiences and beliefs. I was aware of my own subjectivity and how that impacts on the research. As the Clinical Midwifery Consultant at the hospital, there were pre–existing working relationships between myself and the participants. I was in a position where I had responsibility in my working role to facilitate practice change and therefore when conducting research about this practice change, I needed to recognise that my leadership role had influence and power over the participants. My position may have influenced who participated and what was said.

I recognised the participants were constrained by the fragmented medicalised approaches to care. New models of midwifery care are emerging across the world and locally in NSW. A recent policy directive from the NSW Department of Health was published supporting new ways of providing maternity care and this may have been challenging for the midwives to consider. The policy directive is challenging the traditional ways of providing maternity care for all women (NSW Department of Health 2010a; Roxon 2010). This policy directive has been informed from recommendations from many government reports and in the research literature across Australia and internationally (Health Department Victoria 1990; Expert Maternity Group 1993; NSW Department of Health 2010; Roxon 2010).

CONCLUSION

This chapter has described the research design utilised for this project. In summary, a qualitative research design was chosen for the project as it was useful when studying people within their social situation. Descriptive qualitative design was used to explain the situation and content analysis was utilised to make sense of the data.

The next chapter discusses the data collection processes and presents the findings of the three phases.

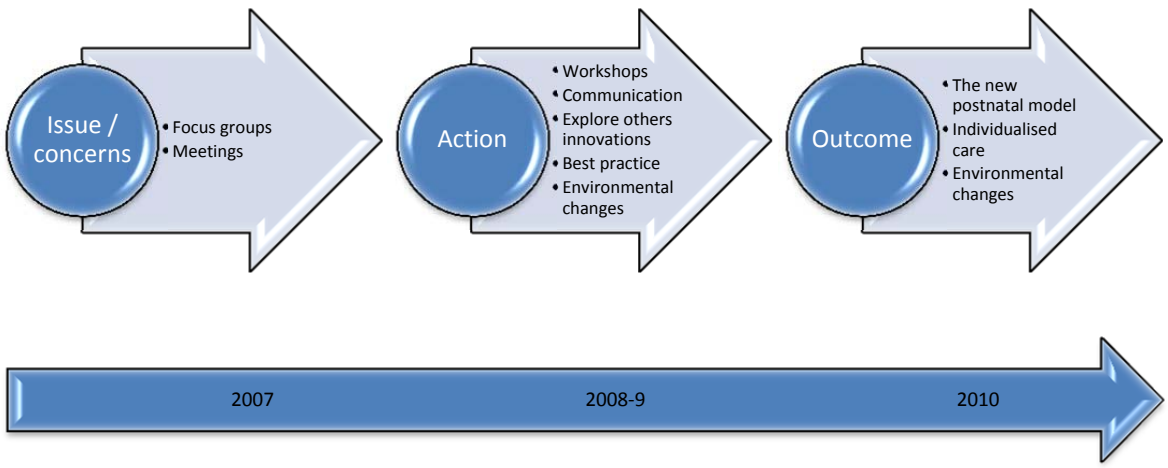
CHAPTER FIVE – FINDINGS

INTRODUCTION

The findings of the study are presented in this chapter. Data collected through three phases including focus groups, interviews, meetings, workshops and other opportunistic encounters were analysed. Field notes supported the other forms of data and were constantly linked with other data collection methods.

A visual concept of the phases and processes that occurred during the research project timeline is provided graphically (Figure 4). The first phase identified the issues and barriers to the care provided on the postnatal ward and the second phase was the action phase. The action phase included exploring midwifery practise with midwives via numerous methods with a view to designing a new model of postnatal care. The final phase reflected upon the processes during the action phase and provided an opportunity to explore the challenges, the barriers and limitations to midwives implementing a new model of postnatal care. The phases and processes are further described in the following section of this chapter.

Figure 4: Phases and processes of the research over the time frame of three years



PHASE ONE – IDENTIFYING THE ISSUES AND CONCERNS

The first strategy in moving towards a new model of postnatal care was to identify the issues and concerns for midwives in providing quality care for women in the postnatal period. Midwives and child and family health nurses were invited to participate in focus groups conducted in the ward and the community. Recruitment strategies for the focus groups were discussed in Chapter Four.

Demographic data

A total of 45 participants volunteered to be involved in the five focus groups and one discussion group. All of the participants were women with the average age being 44 years. The mean number of years registered as a midwife was 16. Over half (58%) of the participants were employed part time and a similar proportion (57%) worked in the hospital in an acute care setting, that is, the postnatal ward. The remaining participants included child and family health nurses. There were 20 child and family health nurses although most (85%) had practised as midwives in the past.

The participants were asked to describe the midwifery education and continuing professional development they had undertaken. Approximately half (53%) had received hospital-based training with the remainder having a university degree. In relation to continuing professional development, 70% of the participants had attended relevant, non-mandated conferences or workshops during the past year. Less than 30% funded their own professional development. The characteristics of the participants are described in Table 3.

Table 3: Demographic variables of the participants

Demographic variable	**N = 45 (100%)**
Years registered as a midwife (mean)	**16**
Non midwives	**3**
Years in current setting (mean)	**8**
Range of years working in current setting	**0-27**
Age	
Range	**25-66**
Average	**44**
Employment status	
Full time	**18 (41)**
Part time	**25 (58)**
Location of employment	
Sterling Maternity Unit maternity unit include home visiting	**21 (48)**
Alexandra Maternity Unit maternity unit – postnatal ward only	**4 (9)**
Child and family health clinic	**20 (45)**
Predominant area of work	
Postnatal / antenatal ward	**8 (18)**
Birthing Unit	**4 (9)**
Antenatal clinic / Foetal Maternal Assessment Unit	**5 (11)**
All areas (including 3 midwives MGP)	**7 (16)**
Community	**20 (45)**
Educational level	
RN and RM with midwifery education (hospital-based)	**24 (53)**
RN and RM with midwifery education (university-based)	**19 (44) both**
Midwives with further / other qualifications	**25 (58)**
Professional development opportunities	
Attended (<12 months)	**30 (70)**
Support from employer	**31 (72)**
Self-funded	**9 (29)**

The next section describes the participants' understanding of the components of care, including their role in relation to quality postnatal care, what they thought women needed and wanted from postnatal care and discussions surrounding the challenges and barriers to providing good postnatal care. Participants were encouraged to further elaborate on their future vision for postnatal services at the research site. The quotes from participants are identified using double quotation marks and italics.

The participants discussed numerous strategies to move from their current model of care to more appropriate ways of providing care for the future. Much of the discussion

focused on midwives' perceptions of the culture of the postnatal environment and what needed to change in order to implement a new model of care.

The participants' perceptions of 'good' postnatal care

Three key themes were identified in relation to the priorities of postnatal care. The main theme was their desire to provide 'good' postnatal care by preparing women for their mothering journey by developing confidence in caring for their baby. Many participants used the term "*empowerment*" and believed that providing women with education was the essential to building women's confidence.

The focus of this thesis was on examining midwives' perceptions of postnatal care; however, it is clearly important to ascertain the views of women. While not a component of the data reported here there was a parallel study, 'A Healthy Start to Life' funded as a partnership between the hospital and the University of Western Sydney with additional support from NSW Health Innovations scholarship. This parallel study involved canvassing women's perceptions of their needs using both a survey and focus groups. The survey was to be undertaken both as a pre-test and post-test design following the implementation of the new model of care. The data from the pre-test survey and focus groups indicated that women in this study site were similar in terms of their needs and concerns after birth to other women reported in the literature review in Chapter Three.

There were a number of aspects of the midwives' role that contributed to good postnatal care and this included providing physical, social and emotional support. At the same time, midwives identified the importance of 'keeping women safe' following birth. The three key themes were:

1. **Education:** Preparing women for their mothering journey
2. **Support**: Providing women with physical, social and emotional support
3. **Safety:** Keeping women and babies safe

These key themes will be further discussed and direct quotes from the participants are provided as illustrations.

Education: Preparing women for their mothering journey

Most participants believed it was important to provide women with all the skills and information needed to become mothers. Participants explained the midwives role was about "*educating*" and preparing women to *"survive"* after birth. If midwives prepared women for the real world of the early weeks of mothering they believed women would gain confidence and self-esteem so they could be an effective and self-sufficient mother. For example, one midwife said:

"It is our biggest role, education … we are here to educate women so they can look after their babies confidently when they go home." FG 4

Midwives felt that by providing education they could help women gain control and feel confident. Participants felt providing positive reinforcement was an important strategy. One newly graduated midwife alluded to this notion of control saying:

"Talking through, demonstrating maybe on yourself or on a dummy or just show her a hold then saying ok you do it and then encouraging her to do it and it just gives them...like positive feedback...getting her to do it so she feels confident with that before she goes home." FG 2

Support: Providing women with social, emotional and physical support

The ability to *provide support* to women for their social, emotional as well as physical health needs was seen by the participants as a priority of postnatal care. However, this was challenging and participants suggested that to be able to provide the support, another member of staff without a 'patient' load was required to do the 'educating' as midwives were caught up in the day to day routines. For example, one midwife said:

"It would be good to have someone devoted ... someone who is totally employed just for educating women in different areas, postnatal exercises, bathing, nappy change, settling and infant feeding." FG 1

Child and family health nurses identified that social and emotional wellbeing was the most important aspect of care and should be prioritised. They suggested that it was important for the midwives on the ward to provide women with opportunities to debrief after birth and talk about what is going on for them. They suggested time was needed to give women opportunities to discuss their birth and feeding experience and provide emotional support. Some explained that if this does not occur they have to "*pick up the pieces"*, for example, one said:

''time to debrief about the pregnancy and birth in hospital is really important we [CFHN] *have to pick up the pieces and try and fill in the gaps if they can't do it on the ward.''* Field notes

While most agreed that women need time to talk, midwives working on the ward had to prioritise the 'tasks' such as observations and medications and therefore could mostly only manage to keep women and babies 'safe'.

Safety: Keeping it safe

Just managing to keep women and babies safe whilst on the ward was a strong theme from the data. Participants explained that 'keeping it safe' meant "*prioritising tasks and focusing on safety"* rather than spending quality time with women. Midwives struggled to provide holistic midwifery care where they could sit and listen to women's concerns and discuss issues with them. Being constantly faced with opposing philosophies of care is highlighted by a midwife in this quote:

"You just make sure the babies have been fed, they [the women] have had their medications, you do the obs [observations] *and things, then you can't do the education too much … the afternoon is busy then it [education] gets missed and then it goes onto the next day."* FG 2

Midwives felt they were just surviving the shift, just managing to keep it safe, keeping watch over the ward. For example, one said:

"You just run fast and keep your eyes and ears open." FG 2

In contrast to the reality of the busy ward and just managing to keep women and babies safe, the participants described what they thought women wanted from postnatal care.

What the participants thought women wanted from postnatal care?

Two key themes became apparent as participants described what they felt that 'women wanted from postnatal care'. The themes were the need for:

- Consistent information
- Individualised and caring approaches to care

Consistent information

Participants felt that women needed "*consistent information"* particularly in relation to breastfeeding and that the information should be conveyed in an "*unrushed"* manner by "*kind and caring midwives"*. Approaches to providing consistent information included having the space and time to provide the information.

Participants identified strategies and ideas to ensure there was time to focus on providing the information, these included:

- Rethinking the team leader role
- After hours clerical support
- Enabling partners to stay longer or overnight
- Increasing the number of staff

Some participants suggested that mothers groups would be beneficial for women to share their experiences and learn from each other. One midwife articulated this by saying:

"*If we had a place for the women to come so they can swap stories."* FG 3

Some discussed having the televisions in the women's rooms loaded with educational videos as a way to provide consistent information.

Participants also identified that midwives themselves lacked education relating to the provision of postnatal care. During the research there was no designated midwifery educator for the postnatal ward. There was one person in this role employed for the entire maternity unit and her priorities predominantly focused on supporting student midwives rostered on the birthing unit. Therefore, there were limited opportunities to provide education to the midwives who provided postnatal care. The participants identified that to provide consistent information they needed additional educational support. For example, one participant explained*:*

"If we all learnt the same information then we would all be giving them the same information." FG 3

Participants felt that women wanted care that was focused on their own individualised needs. They also believed women wanted midwives to providing care in a compassionate manner.

Individualised and compassionate approach to care

Some participants felt women wanted a more "*individual, flexible style of care"*. They also agreed that the midwives must ensure women feel they had been listened to and not just "*fob them off"*. Being able to affirm what women have been through was seen as important as revealed in this quote:

"I think women want to be validated for what they have been through ... they want to tell their story ... and you listen [acknowledging] *and you know, you did so well and just*

validate everything they've been through and I think that's a major thing that I've found that women want, to talk about what happened ..." FG 1

Another participant described the importance of a caring and kind approach as shown in this quote:

"They want a sympathetic, friendly midwife. Someone who's got the time to go in there and talk to them but someone who's not brash and cold". FG4

Flexibility in the ward environment to accommodate the woman's needs was also seen as important as suggested here:

"I've had so many mothers that have said to me over the last umpteen months, "why can't my partner stay in the rest period time" and (I think) if they're going to be quiet and if they are helpful then I don't see why, I don't want their kids or all the other visitors but I don't mind if it's the partner." FG 1

Participants said that being confident to challenge the rituals and routines and the status quo was difficult and required encouragement and support.

Barriers to providing quality postnatal care

Even though the participants' identified what was quality postnatal care and what women wanted, there were numerous barriers to achieving this. The themes that emerged describing the barriers included:

- Staffing numbers and skill mix
- Lack of support
- Lack of opportunities to engage with pregnant women
- Being able to spend more time with women (do midwifery)
- Increasing complex needs of women.

Participants identified that improving "*staffing numbers and skill mix"* would assist midwives to providing quality care. In the current context this was seen as the main barrier to providing quality care on the postnatal ward. Staffing issues and other barriers will be further discussed in the following section.

Staffing numbers and skill mix

The participants described "*low levels of staffing"* on the postnatal ward as a major issue and this resonated strongly from each of the focus groups. Midwives explained it was not unusual for each staff member to be allocated to provide care for up to eight women and their babies. Relying on extra support was difficult, there was no dedicated lactation consultant or midwifery educator for the ward, therefore, the sharing of information with the women was the responsibility of the midwives working that particular shift.

The need for adequate staff was a predominant and recurrent issue. All participants agreed if they had more staff they would be able to provide quality care, this they believed to be the solution to all their problems, as identified in this quote:

"what would help us do a better job would be more staff - it's that simple." FG 3

Another participant explained that management was not really 'in tune' with what was really going on, as highlighted in this quote:

"the managers opinions of adequate staffing is different to what we see ... I'm not saying that we want staff coming out of our ears, but we need enough staff here to give proper care ... if you've got less workload then you've got more time." FG 4

The low levels of staffing frustrated the participants. A few years prior to my research, the team leader was not allocated a 'patient load' and was able to provide education sessions to women. At the time of the focus group, the team leader was allocated the same number of women as the other staff working on each shift. One participant

explained that financial constraints had changed this practice, alluding to a barrier for midwives to be able to provide quality care:

"We used to have education sessions ... the team leader did not have a patient load." FG 1

The participants stated that at the time the research was being conducted, the team leader role included dealing with the administrative and organisational aspects of care. The women allocated to the team leader would often be left to "*fend for themselves*" as the team leaders had to oversee and support the less experienced staff or non-midwives, as illustrated in this quote:

"Now the team leader has a patient load which means you're doubling up ... patient workload plus whatever's happening with the patients your student has got." FG 1

The participants explained that ideally, if all the staff rostered on the ward were midwives and there were more of them, they would be able to spend more time with women providing the care they required.

It was unusual to have only midwives rostered on each shift. Often the manager may have employed non-midwives that is, registered nurses or trainee enrolled nurses, to fill the deficits in the roster. This was not ideal. The midwives recognised that non-midwives working in maternity services are not supported by the midwifery profession (ACMI 2006b).

Midwives reported that they were continually frustrated by the day-to-day management of the roster and on numerous occasions the ward was staffed by finding *"just with a body"*, that is, just another person from another part of the hospital. On many occasions the "*skill mix and staffing numbers on the ward was unacceptable"* and this placed extra pressure on the team leader to ensure woman and babies were safe and received what was considered essential care. It was not uncommon for the team leader to be managing staffing issues by spending time replacing staff due to sick

leave, poor skill mix or overflow on the ward. During the time the research was conducted, there were one or two staff members off sick on a daily basis.

"Poor skill mix and staffing numbers on the ward" was being addressed at the time however it was evident this was a major issue for the participants. Appropriate planning to ensure sufficient recruitment and retention of midwives was identified as necessary. This would ensure safety and quality when there are insufficient numbers of midwives as one participant explains:

"If you're the only midwife [on shift] with not a great deal of support and all the staff around you are … new students or an assistant in nursing, you've got to cover the entire thing and you are responsible for the lot." FG 2

In contrast, when there is appropriate staffing, that is experienced midwifery staff the morale is high as one midwife explains in this quote from a conversation:

"I'm having a great day ... it doesn't matter how busy you are it's who you work with!" Field notes 2007

This quote suggests that if a midwife was only responsible to her allocated women, without being stressed about the rest of the ward, then she would have a "*good day"* and probably be able to provide a higher quality of care.

Clearly, a lack of appropriate staffing was a major issue and reflected the ability of participants to provide quality care to women. During the time of the research, the maternity service employed one clinical midwifery educator and did not have a lactation consultant role these positions were seen as important however there were not enough funds to employ more staff.

Further barriers for midwives to be able to provide quality care included lack of support particularly support for professional development as well as practical support that is, the participants highlighted some of the environmental issues that impact negatively on them such as the ward physical space and equipment.

Lack of support

Participants identified three main support strategies that would assist midwives to provide quality care to women. These strategies included:

- Having more support for professional development
- Having a more supportive work environment

These themes are discussed in this section.

Having more support for professional development

Focus group participants' identified the importance of keeping up-to-date with best practice through regular "*professional development"*. They believed they were not supported in attending local and more formal professional development opportunities. Whilst there were opportunities locally, that is, regular educational in-services and forums, these opportunities occurred during their lunch break and many felt it was important to utilise this as time for them to relax, as described here:

"Lunch is for lunch. It's your time to get away and just have a break in those 8 hours." FG 2

Another example of lack of support professionally included prioritising professional development versus staffing the ward. The managers priority was to coordinate appropriate staffing and skill mix to cover the shifts within the staffing profile as described here:

"I applied for conference leave and she refused to let me go as she didn't have enough staff to cover me that day." Field notes.

Having a more support work environment

Many participants explained that for midwives to provide quality care an effective clinical work environment was also important. The issues identified were a lack of equipment or equipment that was in good working order and not enough clerical

support. On many occasions the participants complained that midwives had to find equipment elsewhere. The participants were frustrated by the lack of support in regards to the equipment as highlighted in this quote:

"... antique and not enough equipment, like we don't have enough blood pressure machines, 2 of our CTG machines are 22 years old." FG 1

"We bought new thermometers last week and they are all gone" Field notes

The participants identified they required more clerical support particularly after hours. Midwives were required to attend to, in addition to the clinical workload, all the constant clerical and administrative activities usually attended to by clerical staff during office hours. This issue of lack of clerical support is demonstrated in this quote:

"It would be great to have a ward clerk until 8pm for the evening because it cuts down your load because they (women and babies) *come in from next door* (birthing unit). *All that paperwork ... and you can have up to five admissions."* FG 4

On a more positive note, participants provided examples of clinical support that worked really well which included, and working together with other health care professionals. The research site had team members from the child and family health nursing team (intake staff) and the social worker located in close proximity to the ward. This strategy enabled effective communication and appropriate referral regarding women and their needs. The participants felt this clinical support enabled the midwives to be able to provide quality care to women. An example of this is shown here in this quote:

"She [child and family health nurse] *is just down the corridor if I'm worried about someone I can just talk to them about it and they will make sure she gets seen sooner that than later."* FG 2

Working predominately on the ward and not being able to rotate throughout the service, presented another challenge for midwives to provide quality postnatal care.

Due to the inflexibility of the maternity service, the midwives were limited in opportunities to engage with women prior to having their babies.

Lack of opportunities to engage with pregnant women

Participants described frustration with the lack of opportunity to engage with women prior to arriving on the postnatal ward. Midwives believed that women arrive after birth often inadequately prepared to care for their baby, particularly in relation to breastfeeding.

There was a sense that women received so much information during their pregnancy and it was difficult for them to absorb it all. The participants felt midwives were unable to explore further with women any issues regarding postnatal care and preparing for motherhood, as there was a lack of opportunity to engage with them prior to arrival on the ward. A participant describing it is "*too late once they have had the baby*", as shown in this quote:

"It's too late to help them breastfeed ... it would be great to meet them in the clinic before they get here, they only focus on the birth and they need to know what to expect when they get here." FG 1

When women arrived on the postnatal ward, the midwives felt they were caught up in all the interruptions that kept them away from the women. The participants talked about the importance of wanting to spend more time with women on the ward.

Doing midwifery in the system

Many participants felt frustrated with not being able to spend time with women to talk about what to expect and prepare them for going home with their baby. Participants felt they were pulled away from the woman to be at the desk to perform non-clinical work.

The non-clinical workload included numerous administrative tasks, for example, answering the phone, policing the visitors, organising the doctors, negotiating with

other staff, including staff from other wards, in particular, staff from the birthing unit. Participants reported that other non-clinical work included managing admissions and discharges and negotiating beds particularly with birthing unit. As a strategy to ensure women received the information and support they needed to parent well, some participants rationalised "*relinquishing some aspects of their role"* to other health care professionals. These professionals included social workers, mothercraft nurses[7] and enrolled nurses. Following a discussion regarding setting up postnatal mothers' groups as one participant explained:

…"it doesn't necessarily have to be a midwife. It could be mothercraft nurse or somebody from community." FG 1

Another way around the issue of providing information to women some participants suggested the child and family health nurse could come and facilitate a session with women before they leave the ward, as the ward midwives could not manage any further increase in workload at the time. The participants felt even though they had a large workload they also identified they were constantly interrupted.

"Constant interruptions", particularly from visitors, were highlighted by the participants as a barrier to be able to spend time with women, for example:

"… when you have the time to give them a bit of education every man and his dog wants to come and visit them … I think it's hard because we can't always give them the proper education because visitors are there." FG 2

[7] EN's undertake an 18 – 24 month course at TAFE or related Health Facilities to achieve a Diploma in Enrolled Nursing. An Enrolled Nurse is a second level nurse who provides nursing care, working under the direction and supervision of a Registered Nurse/Midwife. The supervision may be direct or indirect according to the nature of the work delegated to the enrolled nurse.

Endorsed Enrolled Nurses have completed further medication endorsement to their training (Nursing and Midwifery Office).

The participants explained that women receive less information when they stayed in hospital due to the interruptions, qualifying that when they returned home they are more comfortable with less noise and fewer interruptions. The participants explained the women seemed to take in the information better at home, as shown in this quote:

"But a lot of them don't ask you a lot do say on MSP that they got more out of the visit from the midwife than in hospital ... there's a lot more time, less interruptions." FG 4

In summary, the role of the midwife has become fragmented within the current hospital system. The midwives in this research continue to see their role as a midwife preparing women with confidence for mothering yet they were unable to fulfil this role due to being constrained by the system. Another issue participants identified that impacted on the care women received in hospital included the increasing psychological, social and surgical needs.

Increasing complex needs of the women

Some participants felt that the women accessing the maternity services were increasingly presenting with complex needs. This included more women from lower socioeconomic backgrounds and women who often had child protection issues, lack of emotional and financial support, drug and alcohol problems and a higher proportion of younger single mothers. Providing support for this community of women was difficult for midwives. Midwives were required to organise and coordinate other health care providers and access other agencies including child protection, housing, police and security.

Midwives believed that the need to address these significant issues often meant that these women did not receive some of the important educational aspect of care. Midwives did not having enough time they argued to provide the women with information and support they needed. Many participants also stated that they were caring for more women experiencing caesarean births. This increase in surgical births impacts on the style of care provided:

"it [high caesarean section rates] *can over shadow the midwifery care that you need to do because they* [women following caesarean birth] *are definitely different*..." FG 1

As a consequence of midwives having to provide additional care for women with physical and social and emotional needs, another midwife explained the women with less complex needs are often left to their own devices, as explained in this quote:

"they [women who have had a caesarean section] *take up a lot more time therefore those that are well and had a normal birth ... do miss out on what they deserve..."* FG 1

To highlight further the complex needs of women, a participant described the recent trauma of having a number of babies removed from their mothers and families and assumed into state care as the babies were at risk of harm. One midwife shared this in dialogue with myself and data was added into field notes:

"Assumption of care, it's a huge issue here we had about eight removed from their families in 3 weeks recently." Field notes

The final question during the focus groups asked participants what they thought would be their ideal model of postnatal care. Implementation of a Midwifery Group Practice which provided midwifery continuity of care had occurred during the research and the postnatal midwives noted the benefits that women assigned to the Midwifery Group Practice experienced and felt that women and the midwives were more satisfied with the care. They discussed this style and philosophy of care as being ideal however, could not envisage how this could be extended to include more women within the constraints of the current system of care, instead as discussed below the midwives made numerous suggestions for individual roles that could perhaps plug the gaps.

The ideal model of care

Whilst the majority of participants suggested "*more midwives"* would be the ideal solution, most understood this was not a reality in the current climate of budget restrictions. The vision of the ideal model of care included employing a lactation

consultant, with the intent to focus solely on education related to lactation. The participants also highlighted the need for a clinical midwifery educator to support the student midwives and provide education to the registered midwives on the ward. Participants also described other creative approaches to improve the situation including:

- Continuity of care
- Challenging the medicalised model of care
- Environmental changes
- More support at home
- Increased commitment for professional development of midwives

Some short term achievable changes to the working environment were discussed and will be described later in this chapter. Another suggestion from participants included more commitment to "*more support at home for women"* after hospital discharge. Finally, when asked about a future vision participants felt it was important for them to be more supported for their own professional development as there was a sense they were not supported by the institution.

Continuity of care

Some participants recognised that the provision of "*continuity of care"* was ideal. Knowing the woman prior to the postnatal period and being able to provide women with the information they need to mother well, particularly during their pregnancy journey, would be valuable.

Some suggested being flexible within the current system of rosters and allocation to ward areas to address continuity of care, as the participants explained many midwives stay in the one area. Rotational positions could be offered as this strategy would enable a degree of continuity of care. The midwives stated that they could meet a proportion of women during their pregnancy in the antenatal clinics and, after her birth, they would be allocated to look after them on the postnatal ward.

Other flexible approaches to address continuity of care discussed in the focus groups included, working a few days in the antenatal clinics then the next few shifts on birthing unit. Another suggestion was having a specific antenatal clinic with women allocated to a particular midwife, and then the women would not have to see so many different midwives.

One group discussed providing women with continuity in a team midwifery-style model, where they could see the women during the antenatal and postnatal period. This they saw as ideal as highlighted here:

"We could look at working in our own clinic in the community and then see them on the ward after they have their baby and be allocated to them, then organise their discharge from hospital, then one of the team would see the woman and the baby the next day." FG 3

Implementing a model where the postnatal midwives met with women antenatally would mean that midwives could incorporate information during the pregnancy about breastfeeding to try to address the poor breastfeeding initiation rate[8]. Participants suggested many women have already chosen not to breastfed during the antenatal period. They felt if they had opportunities to meet them before birth, they may have been able to discuss the woman's choice regarding infant feeding. They believed that currently even though this was considered to be part of the role of midwives who worked in the antenatal clinic, they did not believe that these midwives placed enough emphasis on this aspect of care as they would not see them after birth.

[8] It is a public health initiative to improve the number of babies initiating breastfeeding and to increase duration of breastfeeding. The ACM / BFHI fully support the importance of informed decision making. For parents to make fully informed decisions about infant feeding accurate evidence based information must be provided. The information should be provided pre-conception, or as early as possible in the pregnancy, to allow sufficient time for questions to be raised. This then enables individual is able to use all relevant information about the advantages and disadvantages of all the possible courses of action when making a decision (ACMI 2007).

Challenging the medicalised model

Many participants identified the need to challenge the *rituals and regulations* of the maternity ward routines and move towards focusing on what the women want. Participants identified the environment was dominated by a "*medicalised and risk management approach"* rather than putting the woman and her family at the centre of care. The need to shift the culture of care from medical to a wellness model was identified by the participants.

Participants discussed the need for more flexibility in regards to traditional routines. Some midwives argued that the postnatal check can be done any time however some appeared to be more comfortable continuing with a task-focused rather than individualised care approach. A task-focused approach seemed part of the culture, that is, midwives felt it was important to get all the routine care done on the morning shift and this included the postnatal check. In contrast, one participant said:

"It's a twenty four hour shift it doesn't matter if it (post natal check) gets done in the morning or at twelve o'clock at night if the woman's well, if she's not well she would tell you that something's going on." FG 4

"I was only saying that to the girls [colleagues] today because they are panicking … haven't done any postnatal checks and I'm then saying there's three shifts you don't have to do it now." FG 4

However, there appeared to be different cultures within the ward, in relation to ward routines. In particular, there was an unwritten rule that the morning shift should complete the task of doing the postnatal checks on women. Participants explained that they would be made to feel they were "*not pulling their weight"* if they did not have all their routine postnatal checks and tasks completed by the end of their shift, as shown in this following comment:

"But that's the nursing culture isn't it? On the ward you've got to do the ten o'clock ob's (vital signs) by ten o'clock, because the next shifts will whinge about you." FG 4.

Set routines on the ward were also seen as important to the staff and management, as an example of this when others challenge "*the way things are done around here"* is highlighted in this example:

"A heel prick blood test is offered to all women for their baby, this is called a newborn screen test. On the ward the test has been historically carried out on the third day of the baby's life. The blood is tested for numerous metabolic disorders and therefore requires at least 48 hours of feeds therefore the test can be performed earlier than day 3. On this particular day the midwifery educator was working with a student midwife. They were caring for a woman with twins, the babies where at the breast feeding so they attended the Newborn Screen Test when they were two days old. The ward midwife was upset by this and challenged the midwifery educator clarifying that is the way things are done around here and she should not be teaching the student bad habits." Field notes

It was evident from this scenario that the ward midwife was upset as the usual routine was challenged even though this was appropriate care by the midwifery educator.

Many rituals and routines persisted and some less challenging to explore and change. Some environmental issues were discussed. Participants identified there could be some environmental changes within the busy ward setting which could improve care for women. These are explored in the next section.

Achievable small gains

Challenging the usual ways the midwives carried out they daily work routines was seen as a reasonable way to achieve some small gains. Participants suggested ways to reduce "*interruptions"*, included exploring the strict visiting hours which historically created much time negotiating with visitors, utilising non-midwives to perform the non-midwifery tasks, for example, providing ice in the drinking water and bed making, examining evidence based routines for example, regular routine vital signs for women and babies with no risk factors identified and exploring the team leader role.

More support for women after hospital discharge

Participants highlighted that some women can feel vulnerable and alone without enough appropriate "*community support*" following discharge from hospital or from the Midwifery Support Program[9] (MSP). However it was inferred by participants that many women declined to stay on the ward as it was too noisy and midwives felt they were not prepared and needed more support at home, as described here:

"I really hate seeing them on MSP because as soon as they get home that's when the trouble starts and there's no one." FG 4

"we're supposed to be supporting breastfeeding and yet there's no way they can manage that on their own." FG 4

Participants suggested women need to be able to attend a group or have somewhere to go for extra support. A participant in the focus group described a story of a woman, who had telephoned the postnatal ward following discharge home and was distressed saying:

"…she had a hundred and one questions … it was like she wasn't told anything on the ward and I'm sure she had … but somewhere [pause] *where they can go if they go home and feel overwhelmed, somewhere that's a bit familiar or somewhere that's easy to access, it was just lucky that I had time to sit and talk to her at the time but we don't always have that … because she was very distressed this lady and I'm thinking oh what can I do for you … like it's you know I've got this baby now what do I do with it and I'm sure she'd had support in the hospital but she sounded so overwhelmed and it was after hours* [evening] *and I mean I know there's Tresillian[10] and all that but that's not a familiar thing either."* FG 3

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[9] MSP is an initiative to support women after discharge until they connect with CFHN, usually leave hospital early and have on average 3 home visits.

[10] Australia's largest child and family health organisation providing expert parenting advice to families during the early years.

Participants discussed "*individualising the support*" following hospital discharge. Some identified that there could be room for "*more flexibility"* within the current midwifery support program. They considered the short length of hospital stay (2.9 days) and justified providing women with visits that met the individual woman's needs rather than the organisations' needs.

"I think there's more time when you're at their homes but I think maybe we need to be a bit more flexible with the cut offs for what makes them eligible … because often for the first two days nothing is absorbed because they're just getting over a labour and a birth and just trying to figure out how to feed a baby. Then if they're home on day three that's it, that's the cut off, they don't get anybody out at home to see them … it can take up to a week ten days before child and family health follow up so that's when they think now what am I supposed to do? … because that's when they are then going to toss it all in and get upset and feel isolated ..." FG 4

Another participant suggested if the women had more support at home they could avoid that "*spiralling out of control"*, that is, the adjustments to parenthood become unmanageable and become amplified. With more support they could possibility prevent postnatal depression.

Whilst most of the future directions suggested focused on the women, some participants also identified their own professional development needs for the future. Within limitations due to the budget and the cost of education, many felt they could not ask for study leave. Attending professional development opportunities within the hospital was the only alternative unless they paid for it themselves.

Professional development of the midwives

Focus group participants' identified the importance of keeping up-to-date with best practice through regular "*professional development"*. However they also identified barriers to attending local and more formal professional development opportunities.

A participant questioned ways around this issue, as this hospital site does not have 10 hour night shifts. Therefore, the midwives have a limited time for handover, time to debrief or time for professional development via ward in-services as the cross-over time is only one rather than two hours:

"*What about … going back to the 10 hour nights*[11] *and have the shifts start at 1 till 9:30 … so there's a bigger overlap. Handover's done, there's more staff for a bit and then it could be done then."* FG 2

Summary

In summary, the participants felt their main roles included, preparing the woman for her mothering journey and providing emotional and physical support. The participants felt frustrated in their role, as they were challenged in being able to provide "midwifery" to women whilst working in this current medicalised model under the traditional nursing roster.

For the future, participants identified they needed to challenge the rituals and routines and focus on positioning the woman at the centre of care. The participants described the many barriers to providing quality postnatal care and discussed other ways to provide care. With economic constraints, implementing some of these strategies would be challenging, particularly in relation to improving the staffing and skill mix.

The main strategies included being more flexible with ways to engage with women before the birth of their baby and exploring ways for midwives to be able to spend more time with women following the birth of their baby, especially during their stay on the ward. Participants also suggested some small changes could be made to improve the care women receive including; environmental changes such as, opening the visiting hours, providing cold water in bottles, better utilisation of non-midwives; more support after hospital discharge and further professional development of the

[11] An initiative from NSW Health to fund 10-hour night shifts in 2006. This assists staff to better manage shift work hours.

midwives. They believed these strategies would be positive steps in moving towards a new model of postnatal care.

Overall, there was a feeling of wanting to change the current way care is provided however, there was a sense they felt the organisational issues including systems and the increasing complex needs of women was putting a strain on resources, including appropriate staffing numbers and skill mix and could not be changed by them alone.

The next section describes the Practice Development Strategies initiated by the research team following issues identified by the participants from the data from the focus groups.

PHASE TWO – DEVELOPING A NEW MODEL

A Practice Development framework (McCormack, Manley & Garbett 2006) was utilised to organise and facilitate the initiatives and activities. This process facilitates a supportive way of engaging with the midwives and to work together to solve practice based issues (Schneider et al. 2007).

The next section describes the Practice Development framework utilised by the research team in Phase two of the study. This section describes the initiatives employed to engage with the midwives and explore, through a Practice Development framework, the key strategies that might enable midwives to change their model of postnatal care in the acute care setting.

The first step was to generate discussions about the findings from the focus groups and to engage with the midwives and management who were working in the maternity service. In early 2008, I prepared presentations and provided the midwives with feed-back data from the focus groups. This strategy formed a baseline for the discussions and ideas to move forward with the project.

Ongoing regular meetings to facilitate the engagement of all the staff was important as these meeting identified issues about possible changes. Ongoing team meetings were

also held to engage with staff and management on strategies to move change forward. These included critical reflection on strategies and implementation of initiatives. Two groups were formed including a steering committee and a midwives' working group. Further explanation of the groups is provided in the next section.[12]

Implementation of committees and groups

The first group to be established was the Postnatal Care Project Steering Committee. This group was to support the changes identified by the working group. The Postnatal Care Project Steering Committee reported the progress of the project to the Division of Women's Health and sought support and advice as required (see Appendix 4).

The second group established was the Postnatal Care Project Practice Development Working Group. This group reported to the Postnatal Care Project Steering Committee. The Working Group membership comprised the clinical midwifery specialist and midwives working on the postnatal ward who were considered leaders of the group. The research team and the Practice Development facilitators were also members. This group attempted to meet regularly during 2007-2009 but in the end it met on a more ad-hoc basis. The groups worked on activities to challenge the usual way care was provided and to provide support to move towards a more woman-centred care approach. Numerous activities were organised and involved invitations to leading experts in relation to change and postnatal care to the unit for workshops.

Exploring achievable changes identified from phase one

As a way of providing clinicians with opportunities to explore, discover and develop innovations in postnatal care, midwifery staff across the Area Health Service were offered a number of workshops and seminars. The aim of these workshops was to

[12] It is important to note here that the majority of data reporting the chronology and the progress of the Practice development phase comes from my written field notes and reflections. When data comes from interviews or other sources it is clearly reported.

learn what was occurring nationally and internationally and challenge the usual way of providing postnatal care.

Professional Development activities

Funding provided by the Area Health Service, University of Western Sydney and the NSW Health Department (through an Innovations Scholarship) was utilised to provide staff with the professional development workshops. The workshops included international and national experts in the field of postnatal research.

A total of 16 workshops were provided to the staff and 164 participants attended (many midwives attended more than one session). There was also 20 ward based in-services held which were specifically related to postnatal issues. In addition, we held eight three hour postnatal workshops which were also facilitated by the clinical midwifery educator and the midwifery educator employed by the Area Health Service. The midwifery educator employed by the Area Health Service was included as she was an active member of the Practice Development Working Group and was involved with the postnatal ward as her office was on the same floor. The workshops and the speakers are described briefly in the following section.

Workshops with invited international and national experts

In 2007, numerous experts were invited to present their research to the midwives. Three sessions were organised for local midwives and others across the Area Health Service. Professor Fiona Dykes from the United Kingdom, an expert on postnatal care, provided a session on implementing Baby Friendly Health Initiative in the United Kingdom. Dr Lois McKellar, an Australian expert in this field from South Australia provided the results of her PhD work which involved implementing strategies to facilitate information and education for women in the antenatal and postnatal periods with a focus on women's learning needs. Professor Jenny Fenwick from Western Australia provided the midwives with an opportunity to discuss how midwives language acts as a powerful clinical tool and can both facilitate and hinder education and learning.

In July 2008, an all day workshop was organised. Midwifery managers, leaders and clinical midwives across the Area Health Service spent the morning with Professor Deborah Bick from the United Kingdom to explore new ways of strengthening postnatal care provided to women. The aim of the half day workshop was to design a new model of postnatal care. The session started with an overview of the key issues the midwives in this study site had identified in Phase One. The group of 24 participants then explored five key components of care. The participants were divided into groups and 'brainstormed' each component with a view to considering how a new model may be designed, what would be the strategies for implementation and could it be evaluated (see Appendix 5).

At the end of this session, the key components of a new model of postnatal care were identified.

Practice Development Workshops

Practice Development workshops were offered to the midwives employed at the maternity service in 2008. The aim of the workshops was to challenge the participants' ideas about the routine, traditional and ritualistic aspects of postnatal care such as the physical check, with a view to thinking about how this could change. The Practice Development facilitator group explored the usual practice adopting the high challenge – high support utilised in a Practice Development framework. This method supports midwives to explore the issue, by consciousness-raising in a supportive way. For example, Titchen (2006) explains that exploring issues a gentle manner, not in a confounding way, may enable the midwives to see the importance of changing to suit the woman's needs and not the wards, and work towards changing it as a group.

In the workshops, participants were involved in developing a values clarification statement and a ward philosophy emerged. This was an opportunity for midwives to engage with their colleagues and reflect on their work.

Following the values clarification exercise, the facilitators used exemplars to challenge some rituals and routines and how these could be conducted with a more woman-

centred approach. Role plays of 'the admission process' and 'the postnatal check' were presented as part of the workshop, attempting to demonstrate a more woman-centred approach based on self-care rather that a 'strip search style' (a colloquial term for the postnatal check) approach Leap 2000 cited (Byrom & Gaudion 2010).

Regular opportunities for in-service at local site

Weekly multidisciplinary in-services were provided to all the staff within the maternity service during lunchtime sessions. Lunch was provided to encourage staff to attend and was generally well attended, however these were predominately attended by the medical staff and the midwives from antenatal and birthing services. It was difficult for the midwives working on the postnatal ward to attend and they preferred not to come in their own time. On some occasions, myself and one of the members of the facilitator group would cover the ward so postnatal staff could attend the lunchtime in-services.

Addressing the challenges engaging with postnatal midwives

As a way to engage specifically with the midwives working in the postnatal wards, discussions and meetings occurred opportunistically. These were held on an ad hoc basis whenever I could get a group together. Often the members of the facilitator group would cover the ward so others could attend.

The working groups discussed strategies to improve the usual practices employed on the ward. The working group began to challenge usual practices, developed evidence-based protocols and guidelines, focused on interpersonal communication skills and the language used when engaging with women. Underpinning all the sessions was the philosophy of woman-centred care.

Engaging with all midwives working in the postnatal ward was challenging and I was mindful to ensure all sessions were conducted in the work hours of the midwives. As a strategy to engage all the staff with the progress of any changes, I kept the minutes in a folder and posters on the ward highlighting work in progress and invited comments

in written form. This was undertaken as a way of distributing the information. Edwards and Grinspun (2011) suggest providing a spreadsheet which captures the progress and the ways innovations expand through the ward over time, showing who was involved and what activities helped to get it adopted. Table 4 shows each activity, including meetings and professional development workshops and in-services and the number of participants who attended. Further details of the workshops are provided in Appendix 6.

Table 4: Highlights the summary activities which occurred during phase two the action phase

Activities	Number of times occurred	Total number of participants
Steering committee meetings	5	22
Working group meetings	11	67
Practice Development facilitation Working Group	16	164
Postnatal workshop	8	32
Weekly in-services at local site	20	Not measured

Strategies implemented

During and following the Practice Development activities, there were numerous ideas identified for improvement. A summary of the strategies are provided in the following section and include:

- Implementation of a parenting room
- Information for parents
- Evidence based guidelines
- Ward environment changes

The parenting room

The midwives identified that women often do not receive enough information during their postnatal stay in hospital and are relatively unprepared for their postnatal journey. As a way to engage with women during their time on the ward, the working group committee discussed having a quiet place were the midwife could sit with women without interruptions and provide the information they felt that that women need.

Implementing the parenting room

A three month trial was conducted with dedicated staff rostered to provide women and their families' information necessary for parenting and infant feeding. To minimise pressure, the midwife was not rostered to work on the ward and had no other commitments. She was therefore able to focus on providing parents with the information they required.

Preparing the midwives

It was identified in previous research that the way in which information is shared with women is important (Leap & Edwards 2006; Schmied et al. 2009b). The philosophy of self-care and the ability of the women to set the agenda for information and education have been recommended as the best approach, rather than a didactic the 'midwife as expert' approach. In response to this knowledge, the midwives were provided with some skills in facilitating groups. These skills included a one hour workshop which included watching the style of facilitation role modelled in a DVD 'Helping You to Make Your Own Decisions: antenatal and postnatal groups in Deptford, South East London', a film produced by Leap (1991). The style and focus of the facilitation model implemented by Leap and colleagues with women from Deptford in the south of London, allowed the women to set the agenda and the midwife only needs to facilitate discussion and clarify issues. In addition, to further enhance communication and group facilitation skills, a DVD made by the 'Early-Bird group' child and family health team in Sydney was provided for the midwives to watch in their own time.

A parenting room team was established. There were four members and most members of the parenting room team were very conscientious. They developed posters and information handouts for women inviting them to attend the parenting room, explaining they would be providing a space for them to discuss topics, such as, breastfeeding and common problems they may experience following birth. At the time of setting up the parenting room, one midwife was attending a course to become a childbirth educator and was very enthusiastic to start. The midwives were all experienced postnatal midwives and had expertise in lactation and early postnatal parenting skills.

An evaluation was conducted following the trial of the parenting room. Data were collected from parenting room midwives, core midwives from the ward and from women attending sessions in the parenting room. Midwives providing the sessions completed reflective journals and a group meeting following the trial was conducted. Although the feedback was positive, there was a sense that the midwives' initial enthusiasm was diminishing. The midwives on the ward were asked to complete a survey however there was no response. I found a group of midwives at the desk later and asked individual midwives their thoughts and suggestions in relation to the parenting room strategy.

Overall, when women attended the group they found it to be very useful and would recommend it to other women. The midwives facilitating the groups found it challenging both implementing and maintaining the parenting room and identified room for improvement.

Barriers to maintaining the parenting room

The parenting room initiative was implemented in November 2009 and continued over an eight week period. However it became a struggle to maintain enthusiasm over the Christmas period and on numerous occasions, the sessions did not occur. A group was formed to explore the future of the parenting room strategy. This group consisted of myself and my university supervisor, parenting room midwives and ward midwives to

identified issues and barriers to continuing the sessions. The three main barriers identified through one on one interviews with the parenting room midwives and other key stakeholders included:

- the parenting was not incorporated into the existing daily routine within the unit and needed to be
- the cost of staffing the parenting room was over and above the existing budget and may not be viable
- encouraging women to attend

These three barriers to maintaining the parenting room strategy are further described.

Incorporate into the existing daily routine

Many of the ward midwives did not see the parenting room as a priority. The core midwives regularly encouraged the women they were caring for to attend the parenting room session explaining the benefits of attendance. Their motivation to encourage the women to attend the group was seen as a way to take some pressure off them to provide the *"education*" or as part of the information sharing component of care. Interestingly, the ward midwives who were very supportive of the parenting room strategy found the women seemed to be *"checking"* the information they received from the parenting room midwife with them. This suggests the women were *"double dipping"* the provision of information.

The core midwives saw the parenting room as an added benefit however it became apparent that they felt they were spending a great deal time persuading women to attend. The attendance rate was not ideal and at times there would only be one woman in the room. Challenges encountered when engaging women to attend the groups at the parenting room are expanded on the next section.

Incorporating the parenting room into the existing budgetary resources

Whilst initially utilising NSW Health Innovations scholarship funding for staffing the trial of the parenting room, it was understood staffing the parenting room would be

"*incorporated into the existing staff and within their postnatal ward routine"*. It was envisaged when staff and management saw the benefit for women, that is to provide women and midwives with more time to share information and build women's confidence, the strategy of parenting room would continue to be adopted within the existing budget. However, there were no additional resources for the parenting room.

Engaging with the women

Other challenges of the parenting room identified by the midwives included a perceived reluctance by the women to join the groups. Even though midwives were promoting the parenting room sessions, encouraging and *"engaging the women"* to attend, attendance was challenging. Despite producing flyers, displaying posters in the rooms and personally inviting all women in the ward to attend, many did not come. Women were often reluctant to attend because they did want to disappoint their visitors by leaving their rooms. Some women did not think they needed further support while others did not appear interested. Yet the feedback from the parents who did attend was positive.

Below are samples from women's evaluation of their parenting room experience.

"I was not keen on going at first but it was good, I enjoyed it"

"Loved it, the lady was really nice and helpful".

Information for parents - what to expect

An analysis of the focus groups found that midwives felt women were not well prepared for their postnatal journey. As a strategy to address this lack of information, the members of the facilitator group supported the midwives and developed an information booklet. This was a strategy to provide women with information about what to expect following the birth of their baby. The booklet was adapted with permission from the National Collaborating Centre for Primary Care with thanks. The booklet was printed in colour and attached to the bedside lockers as a resource for the women whilst in hospital.

Updated protocols for postnatal care

Clinical practices guidelines needed to be developed in order to implement best practice for routine postnatal care for well women and babies. The clinical practices guidelines were developed using evidence from the United Kingdom to support the midwives clinical practice to a more individualised approach to postnatal care (Demott et al. 2006; National Collaborating Centre for Primary Care 2006).

The guidelines are seen as a tool to support midwives to provide women with consistent information in an individualised approach. Practice Development workshops were also provided at the same time to ensure midwives understood the philosophical framework that underpinned the new policies and procedures.

By providing the midwives with the skills to engage with women during clinical handover and the postnatal check using a partnership rather than expert knowledge approach, it was envisaged it would assist the midwives to change their practice. Table 5 illustrates these strategies.

Table 5: Practice changes with explanation of a woman-centred approach

Routine	Woman-centred approach
Handover at the desk, woman not aware of what is being discussed, therefore she is not involved in her own care planning.	The clinical handover which was conducted in the role play occurred at the bedside and included the woman. Sitting beside her in a relaxed position, rather than at the end of the bed in an authority figure standing over her.
Postnatal check – involves the midwife examining woman and baby from top to toe and ticking boxes on a care plan, limited conversation occurring.	*Self-care assessment approach* explaining with the woman what to expect and what is normal after birth.
Didactic / authoritarian approach to education usually not engaged with the woman.	Utilising positive *language* and sharing information which focused on individualised woman-centred care including family.

Ward environment changes

The midwives in the 2007-2008 focus groups and workshops identified frustration with the amount of interruptions whilst they were working on the ward. The interruptions were frequently taking them away from being with the women.

Strategies to address some of these issues have been implemented by the midwives Lack of rest and recovery time following the birth and issues with visitors and visiting hours were addressed in simple short-term activities that were implemented in 2008.

Lack of Rest and Recovery Time

Modelled from work conducted by Schmied et al (2009b) at another maternity service, strategies for rest and recovery time were adapted for this site. To focus on providing a quiet time for women midwives decided to implement a quiet time before 0800 hours. This time would ensure women were not interrupted by the cleaners, catering staff or midwives unless the woman requested assistance. However, this strategy to address improved rest and recovery time for women was unable to be implemented as

there were many barriers with interconnecting services provided within hospital system.

One of the main contributors to noise on the postnatal ward was the call bell that women press for attention. The call bell continues to ring until a midwife answers it. As a strategy to provide women with more rest following birth, on arrival to the ward, the midwives ask the women to limit the use of the call bells to only urgent clinical situations. This is also reiterated in the orientation pamphlet the facilitation group developed with the midwives early part of the project.

Visitors

The postnatal ward has historically employed strict rest periods when no visitors were allowed to enter the ward. This time was seen as a way to ensure woman get the rest they need following birth. Midwives complained that during the rest periods that they have to answer the intercom constantly as visitors attempt to be let into the ward to visit friends or relatives. These constant interruptions were seen a major barrier for the midwives to be able to spend time with women and provide care.

Due to the restrictions on visiting hours, there were repeated episodes of aggressive behaviour from visitors exhibited towards the midwives. The visitors were disappointed they were unable to celebrate the birth of their friend or relatives baby when asked to return later. During the working party meeting, the midwives challenged the ritual of a rest period on the ward. As a way to address aggressive behaviour toward staff and the constant interruptions that resulted from the intercom buzzing, the midwives trialled an open visiting ward. It seemed that implementation of this trial led to fewer incidences of aggressive behaviours and perhaps a better sense of welcome for family and friends.

These short term strategies, incorporating high challenge and high support, created an environment for the midwives to explore their rituals and routines within the constraints of the hospital system. Providing the midwives with support to challenge

usual systems issues was important as this support and autonomy enabled the midwives to further explore a new model of care.

The proposal for a new midwifery model was developed from the data from the focus groups and from the workshops conducted with international and local experts. The new midwifery model was endorsed by the General Manger and the Director of Nursing and Midwifery. Implementation was however challenging and development of this model requires commitment from the leadership team and is a work in progress. This model is described in this next section.

A summary of the short and long term suggested changes is provided in Appendix 7. Many of these strategies for change are not specifically discussed or mentioned in the thesis and many were unsuccessful.

The New Model

The essential components of the new model of care were identified, these components included:

- engaging and getting to know pregnant women
- continuity of care – based on an antenatal/postnatal community team midwifery model

In the current system, the midwives have no opportunity to meet pregnant women before their birthing event and from experience, they feel that women are not prepared for breastfeeding and parenting. To address the need to *"engage with pregnant women",* to prepare them early for the 'real world' of motherhood, two strategies were proposed. The first strategy included a women's group session at 37 weeks gestation facilitated by postnatal unit midwives. The aim of the group would be to provide women with a postnatal care plan; ideally this would be conducted in a community setting with an emphasis on breastfeeding.

Group antenatal care or Centering Pregnancy has been shown to have benefits (Ickovics et al. 2007). The benefits included social and emotional improvements including development of social networks with other women they had met as a result of the groups. With the success of these groups in mind, the issues of information in the antenatal period were further developed with the participants at the research site. The midwives in the focus groups felt that the information women received during the antenatal period focused on labour and birth issues rather than what to expect after their birth of the baby. As a way to address the need for information in relation to postnatal issues, a second strategy emerged from the working group, an antenatal-postnatal continuity of care model. The midwives stated they were excited about developing a "*continuity of care team midwifery model"*. A small team of midwives could provide antenatal and postnatal care on the ward and in the woman's home for an identified group of women. Ideally, the midwives employed on the ward would be employed in this model.

The model proposal in this research purposely did not include intrapartum care. The midwives stated they preferred not to provide intrapartum care. Providing intrapartum care would be challenging for many of the postnatal midwives for two reasons. Many did not feel confident providing intrapartum care and could not commit to being available or on call for their group of specified women. The aim of this antenatal/postnatal model of care was to provide more job satisfaction for the midwives and the women would receive some continuity of care. It was planned that the team of midwives would provide extended and more flexible individualised home visiting and link together with the child and family health nurses.

This model was in line with the National Health reforms in Australia which is to shift acute care in hospitals to primary health care settings (Commonwealth of Australia

2011; Keleher 2001) and to continuity of care (Roxon 2010). The new postnatal model would address this issue focusing on a primary health care model.[13]

The proposal for the community antenatal/postnatal continuity model of care was published and endorsed by the General Manager and the Director of Nursing and Midwifery in September 2008. However the antenatal/postnatal model of care to date has not been implemented. Difficulties arose following meetings with midwifery managers to explore ways to implement such a model.

Barriers to implementation

Barriers to implementation of the community antenatal/postnatal continuity of care model included incorporating the model within the existing budget and staff profile. The managers were confronted with the challenges of moving midwives from their own existing profiles which they felt was impossible. The managers sought additional funds as they already had staff shortages.

The manager's frustration is demonstrated in the quote below.

"So you're saying I have to give you some of my staff to implement this model? I just can't see how I can do that."

As an alternative model, the managers were keen to introduce a rotation roster system. The midwives would rotate through the three areas of work in the antenatal clinic, labour and birth and provide postnatal care in the ward and community. However, this rotation did not address the issues the midwives identified as important which are engaging with pregnant women, providing continuity of care and providing

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[13] Primary Health Care incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health (Keleher, 2001).

postnatal information during pregnancy rather than during their short stay on the ward.

Summary

Phase two challenged usual practices and explored new ways of providing care in the postnatal ward utilising Practice Development approaches. The activities included implementing a parenting room and altering the ward environment. A new model of care was also designed with the midwives.

The new model with a more flexible approach was not implemented but continues to be on agenda for the future plan for the maternity service. This and other issues were discussed with key stakeholders in Phase three. The next section will describe the final phase which was the analysis of the interviews with the key stakeholders. The interviews occurred in 2010 following the Practice Development strategies and activities.

PHASE THREE – EVALUATION AND SUMMARY OF PHASE TWO

In Phase Three, interviews were conducted with the key stakeholders to examine the success or otherwise of the activities implemented following the Practice Development initiatives in Phase two. Interviews were conducted during a six week period in 2010. They were audio-recorded and the digital recordings were downloaded into password protected files.

The interviews used a series of key prompts and included clarification of the aim of the research, what changes had been successful and those that had not. Further discussion occurred to explore the key stakeholders' thoughts regarding the barriers for implementing changes in the postnatal ward setting. Organisational and managerial issues were also discussed.

Results of the interviews with key stakeholders

The participants represented a range of midwifery leaders and managers to ensure a broad and holistic picture of postnatal services was obtained. The participants interviewed included each of the midwifery managers employed in the maternity unit, midwives who were considered leaders within the unit and midwives identified as change champions who predominately worked on the postnatal ward.

Demographics

A total of nine key stakeholders were interviewed in 2010. Key stakeholders positions included:

- Three midwifery **managers**
- Three **ward midwives** that were identified as change champions
- Three leaders of the practice development **facilitator** group

A total of seven interviews were conducted. The midwifery managers and ward midwives each had one to one interviews with me. Two of the facilitator group had a team interview with the university supervisor.

Four key stakeholders held a relevant university degree. The age range was 27 to 52 years old and all were women. Only two had been recently employed at the institution with the remaining key stakeholders had been employed there for over ten years.

The participants of the facilitators group included me and two colleagues. The facilitators group was considered part of the leadership team in the maternity service. The participants in the facilitators group were actively involved in the postnatal project. They attended meetings and worked closely with me in the Practice Development phase.

Four main themes emerged from the data and will be further examined. The themes were:

- Midwifery leadership within the maternity service
- The culture of the postnatal ward
- Barriers to change
- Confidence and competence

Interviews with key stakeholders predominately focused on the barriers for implementing a new model of care within the acute care setting. The participants stated that they were committed to the proposal for a new model which included the philosophy of woman-centred care. They acknowledged that there were barriers and limitations to implementing such a model. It became obvious that change was unachievable in the current environment and there were a number of factors that impacted on any significant changes. Leadership that focussed on providing quality midwifery care was required.

Midwifery leadership within the maternity service

The participants described the style of leadership governing the hospital. They suggested that the leadership and management style and structure at the institution may have hindered the progress of improving the environment and culture of the maternity service, the postnatal unit in particular. Key stakeholders felt if there was leadership which provided vision and values that permeated the profession, more changes could have happened.

Effective and committed leadership

The management structure, during the time of the research project, involved the three managers of the maternity services who reported directly to the Director of Nursing and Midwifery. The Director of Nursing and Midwifery was accountable to the General Manager of the hospital.

One participant suggested another layer of management was required to focus predominately on midwifery professional issues as highlighted in the following quote:

*"Probably need an extra layer to get on with what we need and get out of their hair [*referring to the Director of Nursing and Midwifery & the General Manager*]. They are very supportive about implementing innovation but we have got to do it." Interview 2*

The stakeholders identified the need for additional leadership in the form of an 'extra layer' of leadership. This would mean the three unit managers would report directly to an overarching midwifery leader. This leader would be focusing on more strategic issues relating to maternity specifically rather than the entire hospital.

To further support this strategy of an extra layer of leadership, another participant suggested if any change was going to occur they would need more commitment and less medicalised focused leadership as described in this quote:

"Do it [the project] *again. Still have to have the consultation, education, staff involvement, commitment but a commitment from upper and middle management leadership to start. Leadership, it just wasn't there for this time. Need a midwifery leader not a DONM* [Director of Nursing and Midwifery] *as she runs the whole hospital mixed in with the medical model, risk management approach."* Interview 2

This issue of all levels being involved and supportive of the change was highlighted. At the time, the three managers felt 'snowed under' or overwhelmed with the managerial aspect of their role. In addition to the usual pressures of managing a busy unit, one participant explained that the postnatal services manager had numerous challenges following the restructure and amalgamation of the two maternity units.

In the chaos following the amalgamation of staff and the day to day 'churn' of the ward, the managers seemed relieved to relinquish the lead for designing and implementing innovative strategies to improve postnatal care. Data from field notes support this as the managers, whilst supportive of the progress, were not actively engaged with activities and not available for most of the meetings. In support of the managers, a participant explained this was a very challenging time as described in this quote:

"The management restructure occurred and the manager had to be in 2 sites … dealing with the angst … she had a lot of difficult people. Waiting for the project to take off she had enough on her plate, just happy for us to implement." Interview 2

When asked about barriers to implementing changes and a new model of care, a strong theme from key stakeholders was the importance of visionary midwifery leadership. The ward needed "*fertilising and nutrients to grow a culture of midwives wanting to change and explore better ways to provide quality care for women and their families"* suggested one participant.

"If an environment is just left to survive on its own it will just maintain the status quo and nothing will change. " Interview 4

Other key stakeholders stipulated if change was going to occur, the leaders needed certain qualities. These qualities of a visionary midwifery leader included being approachable, supportive, open, caring and passionate. For example:

"Leaders and managers need to be passionate about making it a better experience for women and acts on it." Interview 4

There was a feeling that the manager was required to show leadership by ensuring the midwives followed their values statement and for the staff to be more accountable as shown here:

"Clinical midwifery specialist [CMS] *don't do anything it's frustrating and not helping ward midwives e.g. skills drills and education they are suppose to be leaders. Students come to me ... but they* [CMS] *should look after them they get paid more. There is no enthusiasm and no pressure from the manager.*" Interview 5

This suggestion of a more top-down approach to make change happen resonated with another key stakeholder:

"Is there another way to grow the culture of change... authoritarian approach, maybe this is the only way to change ... they (ward staff) won't do the change (suggesting they are happy to leave it up to manager*)."* Interview 3

Qualities of the leader included being approachable and being more of a clinical manager. An example of an effective leader was described by a key stakeholder as:

"I worked with a wonderful manager once, she was caring, her door was always open, she made you feel important, always on the ward and involved with the patients, she was a great clinician." Interview 5

Barriers for being an effective leader included being dominated by administrative issues, and is explained in these quotes:

"Managers these days have to be accountants sorting out budgets and money, making ends meet." Interview 5

"… in between all this we had the restructure, so I think that's probably been one of the most difficult things ... took all the energy out of the project. We weren't sure what we were doing, were we restructuring or were we actually doing the postnatal program [research] *So it got blurred... the staff were resistant and didn't want to be one group ... it took all my focus away, physically away ... but we are now more of a group .. like minded now ... more unified."* Interview 6

Participants explained that having a visionary midwifery leader was important as staff would model themselves on her and better ways of doing the core business. The culture on the postnatal ward is typical of many postnatal wards in acute care settings and is discussed in the section on low status of postnatal care.

Midwives taking responsibility and being accountable

Another theme was to be accountable. Even though the managers are accountable to their staff there is an expectation for the midwives to also professionally accountable in their day to day focusing on their goals and visions.

One participant identified that while managers needed to be accountable for their actions, the ward midwives also needed to work towards addressing their goals and function as a team. This suggests that if a manager and her team are accountable then change can happen as shown in this quote:

"You put up the values statement for all to see, even if you can't achieve it there has to be some degree of accountability of all working there, the clinical midwifery specialists, the manager all need to pull people into line and say that's not the way, not best practice, we all have to be accountable ... that never happens just keep doing the same thing." Interview 4

Despite the midwives developing their values statement, including a move towards a more woman-centred approach to care, the midwives working on the postnatal ward did not embrace this model of care and challenge usual ways of doing, as shown in this quote:

"Why do they sit at the desk? There's no one telling them to get with the women. Acute care setting, too busy, culture is to sit at the desk rather than do the notes at the bedside." Interview 4

Low status of postnatal care

The low status of postnatal care identified in the literature review was evident in this data. The consequence of working within an environment considered to be of lower status was demonstrated from the data. Four main sub-themes became apparent, these were:

- Midwives feeling devalued
- Allegiances with colleagues
- Rituals and routines
- Lack of team work

These themes are discussed in the following sections.

Midwives feeling devalued

Postnatal wards are often under resourced and understaffed compared to antenatal and birthing services. This issue was identified in the interviews. Participants described feeling under-valued which had an impact on the moral of some staff members. Some days they felt more positive than others. However, the mood of the ward midwives can dominate that shift, as described in the following quote:

"There is a woe is me attitude, their mood can impact of everyone else." Interview 3

When staff are feeling more positive and content this can also impact on staff moral:

"I'm having a great day today it's busy but we are all happy and we have good skill mix." Field notes

Some participants describing the midwives as even lazy and apathetic suggesting this was due to lack of passion for the profession.

"Team leader role laziness issue, it's [the role] *hard, you get grief not benefit ..."* Interview 3

One participant, a leader in the ward, had to move away from the ward as she did not feel professionally satisfied and as a strategy asked to be moved to Birthing Unit. There was a sense of midwives not being satisfied or keen and just managing to do what is required rather than going above and beyond.

"When it's not as busy I feel I can give 100% I will always be busy cause I choose to give my time to the women or restocking etc" Interview 5

"it's about the midwives on the ward, it's an entrenched problem some very passionate, but mostly they are very...[pause] what's the word, apathetic, and the way it works these days the churn, the short time on the ward, there is no time. In my day the women stayed longer and you had time, but now all they can do is the bare minimum, and wish them [women] good luck. It's like a chook factory." Interview 2

"it just where they are, some are just in the war zone with young kids, getting the mortgage paid, just get out of here (employed work), that's all they are interested in." Interview 5

This apathy continues and when not particularly busy, the midwives continued to sit at the desk as described in this data:

''We have really busy times and lately the staffing is better but they still sit at the desk even with extra staff they are still doing same thing not giving the women information. Dominant culture of ... part-timers, they don't see the women on the next shift so they just do the paper work, make it safe, baby fed, fill in the boxes. Why do over 100%, do the core business that is it." Interview 6

Allegiances with colleagues

Some key stakeholders felt the midwives preferred to focus on themselves rather than women. This was demonstrated by finding midwives taking refuge at the desk. It was suggested some midwives have greater allegiances with colleagues and are constantly drawn towards the desk rather than being with women.

Working part-time also seemed to make a difference. Key stakeholders explained that when midwives work part-time they may feel an outsider and do not engage in ward activities. One key stakeholder believed that many part-time staff enjoyed the social aspect being with colleagues rather than women stating:

''Part-timers have no commitment to the women, no ownership of the ward or the women." Interview 6

This attitude of building relationships with colleagues rather than women was defended by one key stakeholder:

"I suppose some of it's where there at in their life so their enthusiasm is not there especially when they're part time and they've got little children ... I've been through that myself and I think you're not focused on work ... your career. You're more focused

on everything at home and this is just more of a job that you're in that position and so I suppose you do get a bit slack in your commitment, they've been in that role for such a long time they actually can't update to the role that their meant to do be doing so I've had to look outside that." Interview 1

Another participant adds to this issue of midwives allegiances with colleagues:

"I don't know why [midwives are not keen or enthusiastic], *it's like just do my time and I'm out of here, [pause] could be part-timer element in it. Some are just in the war zone with young kids, getting the mortgage, just get out of here. That's all they are interested in."* Interview 2

However, despite acknowledging the friendships, many of the midwives were perceived as preferring to work in silos. Working in isolation and not as a team was evident as below:

"However they talk about being social and friends but they don't help each other. Maybe it's about looking like they are coping...there's a culture of not helping each other, not answering each other's buzzers, people think they are not coping. Step into each other's role taking over, treading on toes." Interview 6

There was a sense in the interview data that midwives perhaps felt that they were failing or not doing their job properly and as one key stakeholder explained 'midwives were not keen to hand over their workload or ask for assistance' Interview 6

Rituals and routines

When ward rituals and routines are not challenged, the care remains unchanged. If staff are not encouraged to question or challenge out dated non-evidence based practices, nothing happens. As an example of not questioning usual traditions field note data is provided in this text.

Despite the manager ordering more there were no more thermometers left. The staff were asking how they were going to take the babies' temperatures. When the rationale

for performing so many observations of vital signs on healthy women and neonates was challenged, many argued that they were forced to do it, said it was policy. Field notes

Some key stakeholders felt that the ward midwives were so used to the same routines that change was too challenging. They explained that midwives would say *"this is the way we do it around here".* As another example, one key stakeholder explained her frustrations with the inappropriate allocation of midwives to the women at the commencement of each shift. This particular key stakeholder had in the past attempted to work with the midwives to adopt better ways to allocate the women. Despite her best efforts, the allocation of women reverted back to the old way, which suits their own needs rather than the needs of women.

This lack of appreciation of a better way to allocate women frustrated this key stakeholder as there was no consideration of providing women with some level of continuity of staff from one day to the next or consideration of the level of skills and expertise compared to the dependency of the woman's needs. An example is highlighted in this quote:

"They just allocate by bed numbers … you should allocate according to skills of individual midwives, it's not hard, if your good at breastfeeding then be allocated the women with difficulties breastfeeding." Interview 6

Lack of team work

Whilst the midwives may have felt less important compared to those working in the birthing unit there is a suggestion of lack of team work within the midwives working on the postnatal ward. Key stakeholders provide examples of poor team work to the detriment of the care for the women, as described here:

"One of my colleagues helped out in birthing unit for 4 hours. When she came back the others said to her, oh we couldn't get to your women - too busy they [the women] *have*

been buzzing all morning and we haven't had a chance to answer the call bell ... if it's not your allocated women some midwives don't bother answering it" Interview 3

Another theme that emerged from the data in relation to challenges for change is discussed in the next section.

Barriers to change

Interviews conducted with key stakeholders identified that barriers to change were complex. Some believing many of the ward staff resist change to their work life as they were happy enough and did not want to challenge the usual way they did things.

The issue of not taking responsibility and resisting change may explain their lack of enthusiasm and reflection in their own professional development. As an example, some key stakeholders felt frustrated with their staff not wanting to keep updated by attending the organised education sessions. One excerpt from field notes explains this:

"Lunchtime multidisciplinary open forums were offered to all staff with lunch provided as an incentive to attend. These forums were predominately attended by doctors and midwives working in the antenatal and birthing services. The midwives working on the ward said that lunch break was for lunch not education, why should they when they are not getting paid for that 30 minute break." Field notes

Of more concern was the attitude towards work by some of the staff. This attitude could be imitated by others thinking this was the way to get along and survive the ward:

"There's lots of apathy, they have to get home. Intractable behaviors and attitude ... it's not cool to be enthusiastic and keen ..." Interview 3

There was an impression that the midwives came to work to just do the minimum with a culture of apathy, as described here:

"it's about the midwives on the ward, it's an entrenched problem some very passionate but mostly they are very...[pause] what's the word, apathetic, and the way it works these days the churn, the short time on the ward, there is no time. In my day the women stayed longer and you had time, but now all they can do is the bare minimum, and wish them [women] good luck. It's like a chook factory." Interview 2

A small group worked on a proposal for a new job description for the team leader role including developing a 'daily duties list'. A draft job description was then shared with all the staff for their comments. The main changes to the role included reducing the number of allocated women for the team leader. This was seen as a way the team leader could focus on the managerial aspect of care, for example, bed management and allocations, discharges, follow up with medical colleagues and organising baby discharge checks. The team leader role was seen as one that could enable other staff members to be able to dedicate more time with their women with minimal interruptions.

Despite consultations and negotiations, many staff expressed concern and demanded the team leader continue to be allocated the same amount of women as the rest of the team. Even though the midwives had expressed difficulties balancing clinical and managerial care when being the team leader, midwives resisted the change. When challenged by the champion midwives who were leading the change, the ward midwives reacted in a non-supportive way. This excerpt is taken from an interview with a champion midwife describing her experience when trialling the reduced patient allocation for the team leader. Rather than allocating the usual six women she reduced it to four women and she describes the guilt:

"When I did this I felt ostracised and I felt guilty as I had fewer women". Interview 5

A cohesive team and shared vision did not seem to exist on the ward and bullying behaviours were even evident. As shown in this data from field notes, intimidation tactics occurred following a trial implementation of the lesser patient load for the team leader. The midwife champion did not persist as she was feeling very

intimidated. As she describes in field notes taken by the researcher following a debrief conversation:

"I just couldn't argue with them they just didn't want to do it, I have got to keep working with them to survive the culture on the ward." Field notes

Summary

In summary, the interviews conducted with the key stakeholders acknowledged and agreed the rationale for changing the usual way of practice on the ward was supported by staff and management. However, implementation of new models was challenging and difficult to establish. The key stakeholders offered numerous reasons the new model could not be implemented and provided strategies required to start such a model of care.

CONCLUSION

In summary, the findings from the three phases of my research identified midwives wanting to change the way care was currently provided, the second phase included working with the midwives and key stakeholders to develop and new model and the final phase included exploring with key stakeholders the process of change within the research site.

Despite some well-meaning and motivated staff, barriers to moving initiatives forward were complex. The complexities of moving towards a community antenatal/postnatal midwifery model of care, within a hospital ward setting, was challenging within this industrial medicalised approach to care.

Having support from a visionary midwifery leader was identified as being a key ingredient when exploring change within health care. The qualities required in a leader are passion about the midwifery profession and the ability to provide care focused around the women's needs. This can become difficult when managed within a medicalised model.

The next chapter discusses the findings in the context of the available literature and will discuss implications for practice and conclude the thesis.

CHAPTER SIX – DISCUSSION

INTRODUCTION

The purpose of this study was to explore the key elements required to improve the quality of post natal care provided to women within an Australian public hospital. This study was also used to design and implement a new model of postnatal care. In this chapter I discuss the major findings of the study and consider the implications for practice.

The literature review in Chapter Three provided a strong argument for change to the way postnatal care is currently provided to women within an acute care hospital setting. In phase one of this study, the participating midwives and key stakeholders demonstrated their frustration with their role in postnatal care and argued that postnatal care in this maternity unit needed to be redesigned in order to offer a woman-centred approach. Yet, this study, like others before (McKellar et al; Schmied et al 2008), found there were significant barriers to achieving change.

Similarly to midwives in other research, those who participated in this study reported that they had a thorough understanding of what women need and want in postnatal care. They identified education and psychosocial support as well as safety (meaning here the physical health and well-being of mother and baby) as the core elements or focus of care. In order to meet these needs, midwives also identified a series of service and practice principles such as: continuity of care, having a sensitive and caring approach where midwives take time to listen to women's concerns, facilitating visiting so that family can be nearby and providing evidence-based information to women about breastfeeding, infant care and the woman's physical health needs. They also felt that the best place for this to happen was in the woman's home rather than in the hospital.

The midwives identified that women probably needed much more support than they received, particularly while in hospital. Midwifery support in the woman’s home was

perceived by the midwives to be more relaxed and conducive to sharing information. Midwives said they were not constrained by the rituals and routines of the ward when in the woman's home. This has also been reported by others in a range of countries including Australia (Brown et al. 2005; Gilmour & Twining 2002; McLachlan 2008; Rayner et al. 2007; Forster et al. 2007), the United Kingdom (Fraser & Cullen 2006; Gunn et al. 2006; Renshaw et al. 2007; Bick 2006; Cattrell et al. 2005b; Ruchala 2000), the United States of America (Nelson 2006) and across Europe (Ellberg, Hogberg & Lindholm 2006; Fredriksson, Högberg & Lundman 2003).

In Phase one, the participating midwives offered a long list of barriers to the provision of quality postnatal care in Sterling maternity hospital. They were concerned that the fragmented nature of maternity care within the hospital setting meant that they did not meet a woman prior to the birth and the short length of stay did not allow them to spend time with a woman, to get to know her and understand her needs and concerns. This lack of time was made worse by low levels of staffing and poor skill mix. As reported in many other studies (Lavender & Chapple 2004; McKenna, Hasson & Smith 2002; Wray 2006a), midwives were also frustrated by the high administrative workload and the non-midwifery tasks that they were required to complete. It was these frustrations that motivated the successful implementation of some of the initial strategies such as the open visiting hours and the decision to not offer women ice.

In this chapter, I firstly examine the strategies that were used with the midwives to facilitate practice change. I then discuss the 'small gains' made including the collaboration in the design of a new model that offered midwives the potential for change. Finally, the barriers that prevented midwives from introducing the new model of care are addressed.

BUILDING SKILLS TO FACILITATE CHANGE

In this study, the principles of Practice Development were used to facilitate skill development in order for midwives to participate in and lead practice change. Practice Development strategies, such as exercises of high challenge-high support (Kitson 2008)

and working together to explore how to improve ways of caring for women, including a new postnatal assessment policy and role modeling, were used. Change was difficult to imagine within this system of care. The principles of Practice Development aimed to assist the midwives to see that they could change the culture and move towards providing woman-centred care (McCormack & McCance 2006). The principles were used to encourage practitioners to question the usual ways of practice rituals and routines (Walker 2003).

As an example of a high challenge-high support activity, during a meeting with the ward, midwives complained they were struggling to attend to all of the routine observations of the mothers and their babies as there were not enough thermometers. During the meeting I was able to open up discussion and the midwives recognised that women and babies without risk factors do not necessarily require routine observations. They did however explain that the practice was mandated as they were in hospital and the midwives had to be 'seen' to be providing care. Offering change in a positive gentle manner rather than confronting or threatening way was an important strategy in this situation (Titchen 2006). Titchen (2006) suggests that building skills to facilitate change includes three phases that can be used in such a situation, that is, bringing knowledge to the surface, raising awareness of the problem, and reflecting, reviewing and critiquing through debate. Others have found storytelling is useful to help highlight examples of practice and as a way to influence others to identify what is important (Brown & Harrison 2009). During the meeting with the midwives we discussed the intuitive knowledge that midwives possess, yet they have been constrained within the system that insists they perform rituals and routines without question. The provision of support while challenging practice in such a situation is vital. In this case, we explored the evidence and developed a more up to date postnatal procedure for healthy women and babies.

In Phase one of this study, midwives were asked to identify their professional development needs with a focus on what would assist them to provide woman-centered care within the existing model as well as the skills they required to develop

and implement a new model of care. It is important to note here that while all the focus groups highlighted the importance of support for women and families none of the midwives indicated that they needed to strengthen their personal communication skills or the way they interacted with women to provide support. Rather, their emphasis on interaction was on how they best 'educate' the women. Researchers have reported the tendency for midwives to take a didactic approach in providing postnatal care particularly around breastfeeding support (Burns et al. 2012b; Dykes 2006b; Schmied et al. 2011). As in other postnatal settings (McLachlan et al 2009), there is a tendency for midwives to provide 'education' by ticking boxes on a care planner that does not consider what the woman already knows. A woman-centred approach incorporates a more individualised care utilising a facilitative way of sharing information with women, rather than what midwives think women need or have been mandated to provided. In this research, midwives talked of two approaches, that is, when in the hospital the midwives were required to utilise the standardised care plan and tick the education topics they had 'given' the woman, yet when in the woman's home the midwives admitted they just sat and discussed whatever issues came up.

Achieving small gains

Theories of change such as those proposed by (Kotter 1996, 2008) and (Eccles 1994) demonstrate the importance of 'small gains' in the early stages of a change process. Achievement of small gains, which should be visible and unambiguous, serves as a reward and gives them the motivation to continue. This is about rewarding commitment and promoting success to achieve change (Eccles 1994). Small gains help undermine the resistors, making it more difficult for those opposed to change to block them. It can also help move people who may have been neutral about the change, into being more active supporters. Small gains also do a lot to reassure the change agent/s to push ahead with the change as reward for pursuing the appropriate goal and motivating the change agent/s. Achieving small gains gives positive feedback to the change agent about the viability of the change (Kotter 1996). These gains also make the researchers feel that the planning is progressing.

Whilst the midwives believed that there were many things that needed to change to improve the quality of postnatal care, they focused initially on concerns that they themselves could address and that they believed would reduce some of the non-midwifery tasks preventing them from spending more time with women. The early meetings of the working group were preoccupied with what the project facilitators, including myself, considered insignificant or minor issues, nonetheless, these issues such as providing ice to women and 'policing' the visiting hours caused midwives significant stress. This was reflected in the amount of time that the working group spent discussing the issues and the ambivalence of participants towards introducing simple changes. For example, midwives on the one hand felt the task of filing up water jugs with ice was a waste of their time, a non-midwifery task and something that women could do without. But on the other hand, they believed it was an activity that demonstrated to women that they cared about them and wanted to promote their comfort. After lengthy discussions, the working group midwives decided that women could do without the ice and that chilled water would be provided in bottles by the catering staff.

Similarly the decision of whether or not to open up visiting hours from 8am to 8pm and to remove the rest period was fraught with challenges. Midwives recognised that women needed rest after birth and, in most studies, women reported that they find the hospital environment too noisy to rest (Dykes 2006b, 2009a; Rayner et al. 2008; Schmied et al. 2009a). Nonetheless, women also want to be able to have their family and friends with them at this important time and want to determine this for themselves, rather than have it dictated by enforced rest periods. The midwives were ambivalent about removing the rest period. However the task of 'policing' the visiting hours and constantly having to go to open the front door to explain to visitors why they could not come in was frustrating and also left midwives feeling vulnerable as they managed aggressive visitors. Again after lengthy discussions, the decision was made to extend visiting hours.

From the perspective of the midwives, both these actions made a difference to their working day. It is also important to note that these two small changes did not require the working group midwives to prepare any additional documentation such as information for women and families or briefing in relation to the change. The manager was able to inform nursing administration of the change to visiting hours and this was easily addressed. Once all these considerations were refined, implementation of a support person staying overnight commenced and continues.

Building on what already works - Increasing midwifery support at home

Similar to other Australian studies that have explored ways of reorientating postnatal services to increase and provide more flexible approaches to home visiting (Forster et al. 2005; Yelland, Krastev & Brown 2009), there was also a commitment early in this study to increase opportunities for women to have midwifery support at home. This required the reorganisation of current services to increase the number of midwives rostered to provide midwifery support at home from two to three per day. Early working group meetings, which included the manager, explored options using a solution-focused approach described by Walsh et al (2006) to increase flexibility and creativity in rostering. For example, the group designed a roster where the starting times of shifts were staggered. However, there was reluctance to trial this approach. With budgetary constraints, an additional midwife on the midwifery support program was not seen as a priority when compared to adequately staffing the ward. After being on the agenda for four to six meetings with the working group, the issue of increasing the Midwifery Support Program (MSP) dropped off. Notably however, following the restructure of services and the amalgamation of the two maternity units, there were more midwives on the roster and the issue of increasing MSP appeared again on the agenda. Without much discussion there were some shifts where an extra midwife was available for MSP but this was not consistent and did not appear sustainable.

Designing a new model of postnatal care

The most significant achievement of this study was the design of a model of care that would offer women continuity of care and would increase work satisfaction for the midwives. The proposal was developed using information from multiple resources including the data collected in phase one of my research, the literature review and from a full day workshop as discussed previously (see Appendix 8).

VISION, LEADERSHIP AND STRONG MANAGEMENT

There were two key issues identified as the major barriers to change and the implementation of a new model of care in my study. The first was the lack of visionary leadership with the authority to lead change and the second related to the low status of postnatal care and the devaluing of the role of the midwife who provided hospital-based postnatal care. These are both discussed below.

Many of the proposed changes and most particularly the new model of postnatal care required the manager and other organisational leaders to commit to facilitating or progressing the change, both at unit level and at the level of hospital administration. This did not appear to happen in this study and the participants attempted to explain why. For example, managers and midwives alike recognised that the manager of the postnatal ward was constantly distracted by the administrative aspects of the role. The manager's focus was perceived to keep the ward 'safe', including ensuring enough staff for the next shift, rostering for the future and bed management. This resulted in there being little time for implementing any innovative change processes and supporting staff in clinical care.

Other research in maternity services has reported similar issues. For example, Allen's (2009) qualitative research reported the same issue, that is, the midwifery managers were spending a considerable amount of time and energy negotiating adequate staffing and this was their main priority. A major review of the health system in NSW found that nursing and midwifery managers were constantly juggling administrative

business and clinical care which did not met the needs of the patients and staff on the ward (Garling 2008). The seriousness of these barriers was also recognised by the Garling review of health services in NSW. Garling (2008) recommended that managers provide 75% of their time committed to clinical care, rather than be dominated by the managerial aspect of the role. To release the managers from the administration aspect of their role, Garling recommended employment of a new role known as clinical support officers. It was believed that this strategy would enable managers to focus on clinical aspects of care for in patients and more support to the staff.

At times in this study, participants also recognised the challenges that their manager faced. It is not easy for unit level managers to argue for increased funding for positions or equipment within budgetary constraints and that this leads to a sense of disempowerment on the part of the manager and for some, anxiety or concern at not being able to meet the desires of midwives. Curtis, Ball and Kirkham (2006) argue that midwifery managers often feel allegiances to the clinical midwives and to fellow managers and seniors but can end up feeling 'stuck in the middle' (Curtis, Ball & Kirkham 2006, p. 101). The managers in the study by Curtis and colleagues explained they had no control of budgets and did not feel that they could have a say. Managers also felt there was not enough midwifery staff to staff the maternity service and that they did not have control over the baseline establishment or profile of staff to women ratio (Curtis et al. 2006). Issues of staffing were also similar at the research site as the manager struggled with rostering, within a baseline staffing profile that she had no role in determining. The manager was challenged most days to cover the oncoming shifts. In a similar way, Curtis, Ball and Kirkham reported that managers believed that by not providing appropriate staffing they were betraying or losing the trust of their staff and consequently the managers felt staffing issue underpinned the cultural problems within maternity units (Curtis, Ball & Kirkham 2006).

It is also fair to say however, that midwives in my study lacked role models from management. The perceived lack of support from the manager for change impacted on the enthusiasm and confidence of the midwives to change their practice to provide a

more woman centred approach to care. Despite our attempts as the project facilitators to act as role models, we were either not effective role models or we were not in a position of authority and therefore unable to facilitate change. Role model barriers to change in such situations have been well described. For example, research conducted in the United Kingdom by Kirkham (1999) found that the barriers for midwives to change included a lack of role models for midwifery care within a medically dominated institution. Lavender and Chapple (2004) found what midwives recognised role modelling the art of midwifery and focusing of the normality of childbirth could make a difference within the medically dominated wards. A good role model needed a leader with vision for their unit.

The need for visionary leadership

Change requires both leadership and management. Management and Leadership skills are not the same thing, as Firth and Moybray (2001, ii3) describe, "(m)anagement being seen as the seeking of order and stability while leadership is about seeking adaptive and constructive change" (Firth-Cozens & Moybray 2001). Qualities of effective leadership includes having someone with status and respect from the team, someone who is passionate, encourages goal setting and plans action (Lavender & Chapple 2004). Possessing a clear vision ensures a number of important purposes to the change process. Having such a vision means that the direction for change is clarified, it motivates others towards the change and assists in the coordination of others actions so that they are fast and efficient (Kotter 1996).

Managing change is necessary but leadership is crucial. The successful leader works with their team, supports and protects the team and advocates for them (Lavender & Chapple 2004). In successful organisations, leaders foster collaboration. Baker, Kan et al. (2011) found that prior to changing their world, leaders needed to be present and make connections in order to understand the culture. A successful leader needs to be able to deal with the managerial aspects and also understand the challenges for the workers in their day to day work (Baker & Kan 2011). Lessons learnt from their research included the need to work closely with the staff to understand the processes

and difficulties faced to gain a holistic picture of the culture and suggest managers carry a caseload (Baker & Kan 2011). In addition, Lavender et al (2004) found that midwives wanted leaders who were visible, could provide support and were a role model in promoting normal midwifery practice rather than being a 'lap dog for the obstetricians' (Lavender & Chapple 2004, p. 329). The strategy of managers working more closely with the midwives and offering support and developing a greater understanding of their world was reflected by participants in my research.

Leadership that is effective and appropriate is difficult to attain. More often than not, leaders are not provided with opportunities to learn skills to ensure they are effective. Historically many managers have stepped up into management positions after they have been working in that ward for a long time with, little or no additional education or training to fulfill the role. Developing leadership skills is complex and can rarely be learnt by observation alone. Clinicians moving into leadership roles need a sound theory base to understand experience (Legacee 2011).

The characteristics of a successful change agent include having respectful relationships with your own staff, being willing to step in and support when things get tough. Ozaralli (2003) defined transformational leaders having four key elements including:

- Charisma;
- Individual consideration;
- Intellectual stimulation; and,
- Inspiration.

Understanding the styles of leadership would be a useful strategy to facilitate change in the future in postnatal care settings. Bass (1990) explains that there are predominately two types of leadership, transformational and transactional. Transactional leaders do not allow for their subordinates to think for themselves whereas transformational leaders can motivate others to do more than they originally intended. The ways transformation leaders achieve this is by presenting followers with a compelling vision and then encourage interests as a group rather than individuals. A

defining characteristic of transformational leadership is the enormous personal impact they have on the groups' values, aspirations, ways of thinking about work and interpretation of events. Transformational leaders transform followers by transforming followers' values and beliefs' (Bass 1990). Contemplating transformational leadership is challenging within the busy ward areas as midwifery managers are constantly distracted from leading innovations and change as they are only able to contemplate achieving the day to day management issues.

To facilitate innovation, all stakeholders must have the same vision and be supportive. This is not always possible however it has been identified internationally as being essential. For example, in a commentary on a United Kingdom Department of Health report 'Delivering high quality midwifery care: the priorities, opportunities and challenges for midwives (DH 28/9/09)', Warwick stressed the need for development of the midwifery leadership, as well as the full support from key partners in ensuring service improvement (Warwick 2009). The midwifery managers need to access courses, to support skill development for implementing sustainable changes in the ward environments.

Professional identity and feeling valued as a midwife

The participating midwives felt constantly frustrated by the way in which their work was organised, with the feeling that they were 'racing against the clock' (viiDykes 2006b) and a sense of unpredictability and chaos amongst the day to day 'churn' of the postnatal ward. They talked about the constant demands from the birthing unit for more beds. Midwives working in the postnatal ward usually do not experience 'down times' like the other areas of maternity care as they appear to be constantly busy (Dykes 2006b). Overall, the participating midwives in my research also did not feel they were doing a good job and that many things they wanted to do on a shift were left undone. In this context they were unable to contemplate change.

Similarly, Dykes (2009b) describes from her ethnographic study of a UK postnatal unit that midwives felt that they were at the end of a fast medical conveyer belt, and they

were experiencing unrelenting pressure upon their time. She reported that midwives would often 'sigh' as a way to convey they had completed tasks and were about to go home after another busy day (Dykes 2009a, p. 92; Dykes 2009b). My research also found midwives relieved to go home, as they had survived the shift, often not willing to stay back unless they were remunerated to do so. In both these studies, there was a sense of powerlessness to make change.

The negative impact of the fragmented system of care on women was described in the literature review. Kirkham argues however that this style of care can also be disempowering for midwives (Kirkham 1999). Midwives working in this way are more often than not specialising in one area of pregnancy care that is, either antenatal, intrapartum or postnatal midwives and risk losing skills and confidence in all areas of maternity care, when restricted to working in fragmented models of care. In this situation midwives can feel undervalued and become de-skilled (Ball, Curtis & Kirkham 2002; Department of Health 2005). When this occurs, midwives tend to then show an allegiance to the institution rather than to the needs of the woman and her family. As Hunter (2004, p. 216) explains 'midwives working in hospital postnatal wards are often working 'with institution' rather than 'with woman' and midwifery values and beliefs can be buried under a medical production line approach'. Hunter's (2004) research showed similarities to my research, particularly identifying that midwives have little occupational autonomy in their daily work, limiting job satisfaction and sense of achievement. As a way to gain control over their working life, midwives become task orientated.

The status of the role of the midwife has achieved some emphasis in the past decade in Australia. For example, Brodie (2003) used a critical feminist framework to explore issues affecting the current status of the midwifery profession. Her research found that the system of care, within the hospital, was dominated by medicine, with a lack of recognition for the role of the midwife and as a consequence many midwives did not embrace their role as a midwife. Even though the midwifery profession, in many countries is now being internationally recognised and respected, as an autonomous

profession, separate from other professions (World Health Organization 2011), the midwifery profession remained invisible in maternity care (Brodie 2003). Fortunately, this situation is slowly changing in Australia.

When midwives are not able to work in a 'with woman' philosophy they may exhibit emotions such as frustration, anxiety and anger (Hunter 2004). This frustration may impact on the way that a midwife communicates with women and this could be perceived by women as unsupportive, rude, uncaring, and insensitive (Nelson, 2006) and affects the quality of postnatal care. In qualitative research by Wilkins (Wilkins 2006), women stated they wanted help and advice but were reluctant to ask, as they saw the midwives as being too busy. Wilkins warns midwives of the 'aura of inapproachability' that can be generated inadvertently because of task focused approach to work (Wilkins 2006, p. 117). In comparison, when women are allocated to a known midwife in a continuity of carer model, there is familiarity that facilitates ease of communication between the woman and her midwife (Wilkins 2006).

THE VALUE OF POSTNATAL CARE

Midwives sense of powerlessness to do the best job possible appeared to be exacerbated by the low status afforded to postnatal care in comparison with other areas of the maternity service. Other research conducted in western countries has found this to be a common theme (Beake et al. 2010; Bick et al. 2011; Dykes 2006b; Forster et al. 2006; MacArthur et al. 2003; McKellar, Pincombe & Henderson 2010; McLachlan et al. 2008; Rayner et al. 2008; Schmied et al. 2009a; Schmied et al. 2008; Yelland, Krastev & Brown 2009). Participants provided examples of administrative and clinical practices that indicated to them that the work they did was not important compared to other services. These examples include; lack of support for midwives professional development; poor staffing numbers and skill mix; prioritising expertise to other areas and lack of appropriate equipment. On numerous occasions, postnatal ward staff had to support the antenatal and birthing services of the maternity service. The managers or midwives in-charge of shift, were often required to deploy the

midwives rostered to work on the postnatal ward to work in these other services. It was apparent that moving midwives from the postnatal ward seemed easier than moving them from the other areas. Dykes found the unpredictability of being moved from the postnatal ward created a sense of vulnerability, loss of control and a constant feeling of urgency from midwives (Dykes 2009b). My research found that often the experienced midwives would be deployed leaving a less experienced midwife or non-midwives to staff the postnatal ward. This practice of prioritising expertise to the other areas implied to the postnatal midwives that their work was less important. In this context, midwives felt they could only provide the basic care (observations, administration of medications) that they believed would keep women and babies safe.

Midwives working in this way can feel that they are not in control of the work they do, and may become oppressed or demonstrate behaviours of an oppressed group. It was evident in the study that many of the participating midwives did not have a strong sense of identity as a midwife, often referring to themselves and others as 'nurses' and the tasks they performed as 'nursing care'. As Kirkham explains, midwives who are oppressed do not stand up for what they believe in, instead avoid conflict, which 'severely limits midwives' ability to improve their situation' (Kirkham 1999). The combination of low levels of autonomy and high levels of stress means that it is likely that midwives will eventually develop occupational stress and burn out, as Kirkham (2010b) found in her research.

Camaraderie: Surviving the day's work

In order to survive the working environment, midwives tend to prioritise their own needs over those of the woman. When midwives feel devalued as professionals and frustrated with the fragmented system of care, they develop a sense of loss and worthlessness (Lindberg, Christensson & O¨hrling 2005).

As a way to survive the ward environment, it appeared that midwives in my study preferred to spend more time at the desk with colleagues writing notes or talking amongst themselves, rather than being with the postnatal women. The reported

preference of being with colleagues at the desk was a way for midwives to survive the busy ward environment and a reward for a job well done. Hunt and Symonds report similar behaviours in their ethnographic study of labour wards in the United Kingdom. These researchers highlighted how the midwives rewarded themselves after a 'job well done' by sitting in the office with a cup of tea to write up the notes (Hunt & Symonds 1995, p. 104). They also found midwives would often come to the tea room to discuss events and unpack the experiences of being a midwife offering support for the less experienced midwives as a way to survive the busyness of the shift.

My findings suggest that, rather than developing relationships with women, the midwives developed friendships with colleagues. Midwives stated that one of the main reasons for coming to work was the social interactions with colleagues as others have reported. The importance to staff of developing relationships with colleagues has also been reported by others For example, Janssen's (1999) study of nurses in the Netherlands found that social support from colleagues was important to help nurses manage emotional exhaustion. Another advantage of staff fostering friendships at work, is that it may address issues of staff retention (Izzo & Withers 2002). Sullivan, Lock and Homer (Sullivan, Lock & Homer 2011) research found midwives stayed in the profession as they felt a sense of belonging as they developed midwifery relationships.

Reluctance to change

Many believe that the answer to the lack of control and autonomy that midwives experience in relation to their daily work in a postnatal unit is for midwives to work in continuity of care models. Midwives working in 'midwife-led' models are more satisfied professionally as they have autonomy and control over their working lives (McCourt, Page et al. 1998; Sandall, Davies et al. 2001; Kirkham, Morgan et al. 2006; Homer, Brodie et al. 2008). However in my study, for most of the participants, working in a Midwifery Group Practice did not appear to be an option and even the thought of putting in place small changes was risky. Few, if any of the midwives, were prepared to take a lead on any of the change strategies. The parenting room provided a good illustration of this. While the manager supported the introduction of the parenting

room, there was very little else in her behaviour or actions that implied, to the midwives, ongoing support. Of the three midwives who were keen to facilitate the parenting room, one initially appeared as the leader and took on the role to develop information for women. However, when the products were not forthcoming or finalised, the other team members were reluctant to question or request this information from their midwife colleague for fear of entering into conflict with this midwife. Kirkham (1999) also reported that midwives avoided conflict or uncomfortable situations, which she proposed was linked to the oppressed position that midwives were in.

The right timing for change

In most of the meetings and key stakeholder interviews for my study there was discussion of the long term stress caused by the planned and then final amalgamation of two maternity services. Although the merger of Alexandria maternity unit with Sterling unit led to an increase in the number of midwives, the change required brought significant stress to the manager and other staff. In a similar way, two Americans, Bingham and Main (2010) reported on their experiences of implementing change in a range of settings, identifying the importance of having a local context that is ready for change together with strong leadership able to motivate staff for change. On reflection, the time for change in our postnatal unit was fraught with challenges as so many organisational changes were occurring prior to and during this research.

It is important to consider the context when exploring new ways of practice including the socio-political environment, state-wide policy initiatives and mandates, inter organisation norms settings and networks and the environmental stability. These issues can impact on the successes or not for change environment.

LIMITATIONS

It is important to recognise limitations of this study. The limitations included some practical issues and challenges that were unavoidable. The practical issues included

numerous challenges when attempting to engage with midwives during their work time rather than their own time. There were also challenges engaging with a predominately part-time workforce as the staff were not always available. In addition, the length of time the research was conducted meant some midwives were not involved in the project and the momentum was lost.

Engaging with the postnatal midwives and manager

Change in health care is complex and a key element to change, is being able to engage and involved all staff (Bingham & Main 2010; Casey et al. 2011; Greenhalgh et al. 2004; Kitson 2008; McCormack, Manley & Garbett 2006). During the process, the staff become supportive and understand the rationale for changes, however to gain a shared commitment the team must engage with all staff which was a barrier in this research.

Eighty five percent of the midwives were employed part-time. This issue of 'not being there' creates a barrier for engaging with all staff. For Practice Development work to be successful, engaging with all staff helps in the change process as the staff have invested interest in making change happen (Kitson 2008; McCormack, Manley & Garbett 2006; Wilson 2003). This project occurred over a three year period and during that time staff moved in and out of the ward either on a rotational basis or left the service entirely. This issue was identified and strategies were adopted by the researcher to engage with the majority of midwives. One approach to ensure others were kept informed was via the smaller group of 'change champion midwives'. It was envisaged that they would discuss the initiatives developed with the wider circle of clinicians within the unit, however this sharing of information had its limitations. The change champion midwives actually had limited confidence to challenge and negotiate with their peers. This small group felt their allegiances had changed and perhaps they were not part of the team anymore. On reflection, the change champion midwives were placed in vulnerable position with the resistors. Providing more support in the facilitator's role during these challenges was required.

Another strategy to keep midwives engaged and informed with the work in progress was via written communications. A specific communication folder was provided in the tea room and staff were invited to 'read when they could'. Incorporated in the folders were minutes of meetings, draft policies and procedures and information for women handouts. Unfortunately the midwives did not actively participate in this strategy to engage in the project and, on occasions, the folder was misplaced. I also attended numerous ward meetings at communicate progress on the project. However, if I did not attend the ward meetings the main focus and agenda items predominately related to day to day management issues and therefore in reflection I should have made it my priority to attend. This was a missed opportunity for communicating the progress to the midwives that could not engage. This is an example of the researchers having to be relentless in moving change forward, if no-one keeps things moving it just fades away in the usual business of a hospital's acute care issues.

Unfortunately the manager did not engage in many activities, as she was constantly distracted by management issues particularity staffing issues. On reflection, keeping her 'in the loop' and working closer together was important, however at times it was difficult for her to absorb and engage in the planning phases for changes. Leaving change up to one particular individual is not achievable in a bottom up approach in the vein of Practice Development. The framework relies on staff to engage in activities, planning, implementation and evaluation.

Overwhelmed with change

During the period the research was conducted, there had been many changes preceding and during that time. These changes included recommendations from a Government inquiry which changed: the high level managers, the maternity management re-structure, the closure of the Alexandra Maternity Unit and the midwives from that particular unit had to move to the busy medicalised model of care. These overwhelming changes probably contributed to the difficulties in my study and are considerable limitations.

CHAPTER SEVEN – IMPLICATIONS FOR PRACTICE

Over the past two to three decades the quality of postnatal care women receive in hospital has been challenging and not always focused on the needs of the woman and her baby. There have been numerous recommendations in the literature urging midwives and leaders to put the woman at the centre of care, incorporating more flexible approaches within the acute care setting which allows a relationship based care approach. However, as this research has shown, shifting the philosophy of care within the constraints of the institution of hospital-based care can be challenging.

Challenging the traditional rituals and routines within the acute care setting is possible however, midwives require more support. Numerous factors that restrict the provision of woman-centre cared were identified in my research. These included increased leadership support, for the need for continuous professional development of the midwives, and more flexibility and autonomy within their practice.

Visionary midwifery leaders

Moving the team through change is complex. Having a vision for the future and working towards this vision is imperative, articulating the vision with colleges and working together to implement the change requires a visionary leader with certain characteristics. The skills and knowledge are usually not gained whilst on the job. Further skill development is required.

Leadership training

Leadership training is needed. A report from the United Kingdom (Department of Health 2008) in relation to improving leadership in the workforce, identified the need for clinical leadership development training. In Lavender's et al (2004) research midwives suggested employment/promotion of leaders with vision was important. The Department of Health in the United Kingdom are committed to introducing training and offer a new standard in healthcare leadership including a Leadership for Quality Certificate (Department of Health 2005). The NSW Health Department understands the

value of training leaders and whilst not mandated, the Nursing and Midwifery Office in the NSW Health Department offered clinical leadership development named 'Take the Lead', which has shown to improve personal and professional development (NSW Health Department 2005).

Highlighted in my research was the need for more support from the manager and leaders of the organisation. The recommendation would be to explore the competency standards of the leaders and work towards developing skills for transformational leadership. In the future recruitment of midwifery leaders should incorporate essential criteria of transformational leadership training.

Commitment to Continuous Professional Development for staff

Supporting midwives professional development was challenging within this research site with the current cost containment climate. Midwifery educators play an important role in providing staff with on the job training and updating evidence based practice. As a strategy in my research, to engage in professional development activities, lunch time open forums were conducted, modeled on another maternity service in Sydney (Homer 2001). However, many of the postnatal midwives chose not to attend the open forums as they believed lunchtime was for them to eat and relax.

Providing empowerment structures for the education of the staff should be a priority as this leads to improved self-esteem and as a consequence may improve work effectiveness (Davies, Spence Laschinger & Andrusyszyn 2006). Recommendations from my research include, being clear about the priorities of the role of the educator, by providing opportunities, support and information and resources. In addition the research recommends the organization prioritise flexible shift times to provide opportunities to provide midwives with in-services on the ward. One strategy recommended would be to test ten hour night duty shifts.

Improve communication skills of the staff

Communication of staff is important. My study identified that midwives viewed that their main role was to 'educate' women so they would be confident to take their baby home and mother well. The research site like many others within an acute care setting, utilise a care planner, due to limitations of a fragmented care approach, and midwives provide 'education' to the women by ticking off identified important issues to be discussed. The tick box approach does not consider what the woman already knows. My research identified two models that is, when in the hospital the midwives were required to tick the education they had 'given' the woman, yet when in the woman's home the midwives admitted they just sat and discussed whatever issues came up.

A recommendation from my research is to offer and support midwives opportunities to develop different approaches in the way midwives share information with women. The environment should facilitate privacy with no interruptions and importantly be conductive for women to set the agenda rather than the authoritarian approaches. Gunn (Gunn et al. 2006) argues midwifery and medical training does not equip practitioners in the appropriate skills in relation to psychosocial risk assessment and developed a training program to meet the needs of women at risk, and the staff gained overwhelming confidence in advanced communication skills (antenatal) (Gunn et al. 2006).

Developing effective communication skills have been identified as a key element to providing women centredness. Interestingly Schmied et al (2009) found midwives lacked the skill and confidence to address women's educational and support needs as they tended to offer women information in a didactic and task focused manner rather than in a facilitative way. Research conducted with Child and Family Health Nurses found similarities and recommended health systems should support Child and Family Health Nurses in changing from a model of expert to partner, consistent with primary health care practice (Kruske, Barclay & Schmied 2006). Furber (2010) found language used often would undermine the women, and recommends compulsory communication workshops.

Providing midwives with the skills and support for prioritising time to talk to postnatal women, ability to listen to what it is she is saying, acting appropriately to her needs, enable her to feel supported and getting to that place in her own steam in her own time in a facilitative approach rather than top down, should be the focus of care for women and were the priorities in Fenwick's research (Fenwick et al. 2010).

Support for partnership training

It was identified from my research that midwives lacked confidence and skills in facilitating group discussions and utilising more woman-centred language and approaches. The two day workshops provided for the midwives was well received by the midwives based on Family Partnership training model (Davis & Day 2010; Quinn 2011).

Whilst focusing on antenatal care, Gunn, Hegarty et al (2006) provided and recommended an education training package for health care professionals. The program conducted in Melbourne, provided midwives and doctors with the skills required to approach and manage the complex psychological and social needs of women. Educational programs are recommended as Gunn's (2006) research showed staff report they felt more competent to be able to identify and care for women with psychological and social issues.

The Role of the midwife

In contemporary maternity units, some midwives need to re-establish their confidence as a midwife in her own right, not secondary to other health care professionals. However, regaining confidence is challenging, when dominated by medical and nursing knowledge, and skills mixed into the practice of midwifery (Thomas 2000). The postnatal area is predominately a midwife domain (Glazener, MacArthur & Garcia 1993) yet midwifery does not always flourish.

In the role of Clinical Midwifery Consultant, I attempted to encourage midwives to further develop professionally, some completed higher education, however many

were limited by social issues or perhaps lack of enthusiasm. Lack of enthusiasm could stem from lack of relationship based leadership as Bryom and Downe (2010) suggests, following her qualitative research into the qualities of a good midwifery leader, moving away from the hierarchical style of leadership, which is commanding and controlling, to one that is based on the relationship, shifts the focus to a more woman-centred care approach.

It is a reasonable start if midwives are willing to absorb new knowledge and are receptive for change (Zahra & George 2002). The group of midwives should be working towards the same vision and have supportive leadership to move forward and explore new practices. However, this was challenging in the current context at the research site, described in Chapter Two. Issues involved instability at all levels as there were the closures and restructure of the maternity services. The capacity for the midwives to be receptive and explore changes was relatively limited. Challenging their world as they had known it to be requires further exploration.

Being the researcher and facilitator

Being the researcher and facilitator in this project was challenging yet rewarding. Walsh, Moss and Fitzgerald (2006) suggest that to rekindle, stimulate and motivate the team, the facilitator must rise above the despondency and apathy. Researchers suggest learning from successes, and not leaving the team to rely heavily on the facilitator. Having the skills in 'motivating the de-motivated' is essential.

Challenging the status quo as Walsh, Moss et al (2006) explain can be challenging and proposes Practice Development facilitators approach challenges in a more positive way, looking at the strengths of the team and using a more solution focused approach. By reframing the issues in a gentle manner, rather than blaming others, Walsh, Moss et al (2006, p. 147) suggests asking the group the 'miracle question', what would their idea model look like? How would they see the ward if it was transformed overnight? What would be different? Understanding their situation and their barriers, as the facilitator is vital. An important skill of the facilitator is not to impose change, but

provide a high challenge-high support approach. It is difficult to be successful without input from the high level midwives and the manager.

CONCLUSION

The introduction of a new model of postnatal care within the acute care setting, has the potential to create a more effective way to provide quality care that responds to women's needs. Traditional postnatal care has remained relatively unchanged since moving from community to hospital where care has focused on medicalised approaches and with a philosophy of risk management approaches rather than focusing care on what the woman needs.

There has been a reliable amount of research highlighting the need for improvements in the current way postnatal care is provided to women in hospital. Postnatal care continues to be based on traditions, built on rituals and routines and not on the available evidence signifying a need to change.

Despite governments, researchers and consumers urging the current system to move towards a more woman-centred model that meets the needs of women and their families, change has been slow. Change in health care is complex and there are key elements required to move change forward. My research found the barriers to change to be the philosophy of care within the maternity service; managing the day to day issues; staffing and skill mix issues; low status of the postnatal service, managers' and midwives confidence and the facilitators' support and skill to facilitate change.

Prior to, and during, the research there had been several significant events that negatively influenced developments involving change. Previous events are important in shaping a culture within a health service and the individual units needs should be considered before implementing more upheaval. A commentary from Rycroft-Malone (2008), from the Centre for Health–Related Research in the United Kingdom, found the context for change is important when considering success. It is vital to have a culture for change with strong team work, suggesting the whole system needs to change from

individuals, teams and the organisation. Davies, Edwards et al (2006) urged key leaders to modify their organisations by investing in key individuals at multiple levels of the organisation.

Maternity care goes beyond just ensuring a safe clinical outcome but the way care is provided has a profound social consequences for generations to come, and can impact on health in years to come (Page 2001). When a midwife is able to provide the right support, a woman requires during her major life transformation as she becomes a mother, the woman will feel powerful (Page, 2004). Midwives have a critical role to play in this important period and systems to enable this to occur need to be developed and tested remembering the lessons learnt from this thesis.

GLOSSARY OF TERMS

TERM	DESCRIPTION
Assumption of Care	Section 44 of the NSW Children and Young Persons (Care and Protection) Act 1998 provides for the assumption of care responsibility of a child or young person (0-17 years). Community Services can assume care of a child or young person suspected to be at significant risk of harm if they are satisfied it is not in their best interests to be removed from the hospital or other premises by their parents. (Ministry of Health 2011)
Birth centre	A birth environment within a hospital setting, purposely home like, rather than a clinical environment which focuses on natural birth for healthy women. Women accessing birth centres are motivated to achieve a natural birth without unnecessary medical interventions
Caseload	The caseload midwives have individual primary responsibility for a specific number of women per year, working in a supportive group of midwives called a Midwifery Group Practice (Homer, Brodie & Leap 2008).
Centering Pregnancy groups	Centering pregnancy an innovative model for prenatal care integrating broad health education and group support with prenatal investigation
Continuity of care	Midwifery continuity of care usually begins in early pregnancy until the end of the postnatal period. Care is provided by the same midwife or a small group of midwives
Continuity of carer	Primary midwife provides the majority of the care throughout the early pregnancy to the end of the postnatal period. Continuity of carer sometimes named one to one midwifery or midwifery caseload practice (Homer, Brodie & Leap 2008).
Family day Stay – e.g. Tresillian or Karitane centre	Child and family health organisations providing expert parenting advice to families during the early years
International Practice Development Schools	Schools are hosted by the International Practice Development Collaborative (IPDC) collaborators. The program and resources are agreed by the members of the IPDC within a dynamic framework of constant evolution following experimentation and evaluation.

Maternity service level (was known as role delineation)	Level 1: local maternity service (no births), postnatal only for women with normal outcomes. Level 2: small maternity services, normal risk pregnancy and births only. Staffed by general practitioners and midwives. Level 3: country district and smaller metropolitan services, care for mothers and infants at normal and selected moderate risk pregnancies and births. Full resuscitation and theatre facilities available. Rostered obstetricians, resident medical staff and midwives. Accredited general practitioners specialist anaesthetist on call. Has Level 2b neonatal care. Level 4: regional referral metropolitan district services. Birth and care for mothers and/or babies with moderate risk factors. Obstetricians and paediatrician available 24 hours a day, 7 days a week. Rostered resident medical staff, specialist anaesthetist on call. Has Level 2b neonatal care. Level 5: regional-referral-metropolitan services, care for mothers and infants known to be at high risk. Able to cope with complications arising from these risk factors. Has Level 2a neonatal care. Level 6: (tertiary) specialist obstetric services (supra regional). All functions normal, moderate and high risk births. Has Level 3 neonatal intensive care (NSW Department of Health 2010b).
Midwife	A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical

	or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counseling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practice in any setting including the home, community, hospitals, clinics or health units.
Midwife-led model of care	A primary maternity facility offering 24-hour midwifery care for women having an uncomplicated pregnancy and birth and has the capacity to respond to unexpected emergencies. If medical care is required women are transferred to a higher role delineated facility. Women accessing the midwife-led model are allocated to a known midwife within a group practice (Tracy et al. 2005).
Midwifery group Practice	A group of midwives providing primary care, which includes all aspects of pregnancy care, to an allocated number of women for their pregnancy journey.
Placenta praevia	Abnormal placental implantation site and is classified according to relationship of the placenta to the internal cervical os. Can be total, partial, marginal or low implantation (Hacker, Gambone & Hobel 2010).
Placenta accreta/percreta	Abnormal attachment of the placenta through the uterine myometrium maybe superficial (accrete), or the placental villi may invade partially through the myometrium (increta), of extends into the uterineserosa (percreta)(Hacker, Gambone & Hobel 2010).
The Health Care Complaints Commission	The Health Care Complaints Commission (the Commission) is an independent statutory body established in 1994 to investigate complaints about health care services in New South Wales. Where the Commission investigates complaints against health care organisations it can make comments and recommendations about how to make the health care service safer and better for patients. When it makes comments and recommendations, it provides a report to the New South Wales Department of Health. The Commission also has the power to prosecute disciplinary cases against individual registered health

	practitioners if grounds exist and it is in the public interest.
Primary Health Care	Incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health (Keleher, 2001).
Woman-centred care	Woman-centred care is a concept. It implies that midwifery: • Focuses on the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professionals • Recognizes the need for women to have choice, control and continuity from a known caregiver or caregivers • Encompasses the needs of the baby, the woman's family and other people important to the woman, as defined and negotiated by the woman herself • Follows the woman across the interface of community and acute settings • Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations • Recognises the woman's expertise in decision making (Leap, 2000).

Appendices

Appendix 1 – UTS ethics approval

14 July 2009
Professor Patricia Brodie
Faculty of Nursing, Midwifery and Health
CB10.07.209
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Patricia,

UTS HREC 2009-096 – BRODIE, Professor Patricia, SCHMIED, Associate Professor Virginia (for PASSANT, Ms Lyn, Honours student) – "What are the key strategies that enable midwives to implement a new model of postnatal care in an acute care setting?"

Thank you for your response to my email dated 20/05/09. Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics clearance is now granted.

Your clearance number is UTS HREC REF NO. 2009-096A

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9772.

Yours sincerely,

Professor Jane Stein-Parbury
Chairperson
UTS Human Research Ethics Committee

Appendix 2 – Letter addressing ethical concerns

10th June, 2009.
The Ethics Secretariat
UTS Human Research Ethics Committee

Research and Innovations Office,
PO Box 123
Broadway.

Dear Professor Jane Stein-Parbury,

Re: Project 'What are the key strategies that enable midwives to implement a new model of postnatal care in the acute care setting'.

Ref no: 2009-096

Thank you for your email 20th May 2009. Below I have outlined my response to each of the questions raised by the committee.

The potential risks had been understated, particularly given the difficulty of maintaining confidentiality/anonymity in the research

- I first address the issue relating broadly to the type of risk that may be present. I then address issues related to confidentiality. Postnatal care is perceived by some to be the least important area of maternity care. It is possible that some midwives working in the postnatal unit at this hospital may have this view of postnatal care. Participation in this study may contribute to them feeling less valued professionally and as individuals, particularly if during the action research process the current status of postnatal care is challenged or considered to be deficient or inadequate. Some midwives who participate may somehow feel that it is their fault that women do not perceive postnatal care in a positive manner.
- Many midwives in this unit however, have already expressed their dissatisfaction with the current system and state they are ready for change. It is hoped that the action research process will assist participants to reach agreement on what needs to change and how this should be done, as well as to then put the changes in place and to evaluate these.
- Action research has the potential to bring reflective practice and emancipatory action together in a way which may also challenge the existing relationships between the staff. Therefore, there is the potential that some midwives and other staff who agree to participate may experience a level of inter personal conflict and psychological distress, including feelings of distrust, worthlessness, oppression, distress and anger during the research.

- The potential for this harm will be addressed in several ways. First, all staff will be invited to participate in the process of changing the approach to postnatal care. This is an important strategy to ensure the midwives have a sense of control over the process. It will be stressed that participation is voluntary and that participants may withdraw at any time.
- I acknowledge there are different levels of education and experience among the midwifery staff and some may not be interested in any change or for some reason may not be able to participate. I acknowledge midwives may have had a poor experience with a top down approach to change and therefore do not have faith in the system or any other process for change. As action research is a 'bottom up' approach, that is it is democratic and inclusive, this method may motivate the staff to engage. However, if midwives choose not to participate their reasons will be respected and there will no pressure to continue to contribute.
- The meetings and workshops will be held on different days of the week and many staff work part time. It is therefore unlikely that participants in the action research meetings will know who has participated and who has not.
- Feedback with research participants and the institution will be provided on a regular basis using strategies such as: providing staff with minutes from meetings, outcomes of workshops and focus groups, via presentations to hospital staff. This will provide transparency and provide all staff with information and progress so they all feel included, listened to and respected. This will be done in a way that maintains confidentiality (see below).
- When the focus groups are conducted at the end of the project to discuss the action research process including what has occurred and what has changed, the participants will be offered the opportunity for someone else to facilitate the discussion. For example one of my supervisors, Associate Professor Virginia Schmied would most likely be suitable as she is not employed by the (de-identified) Area Health Service and has no line of authority for the staff.
- If any research participant were to become distressed during the interviews, focus groups or in the workshop providing feedback of the findings, I will employ the following steps:
- Offer the opportunity to discontinue participation in the interview, focus group etc at the time and offer the chance to participate at a later stage.
- Offer the participant the choice to discontinue in the study emphasising that any data they have contributed will be removed from the dataset (although the participant will be told that this may not be possible with focus group data) and that their withdrawal from the study will not impact on their relationship as an employee with the area health service.
- At the time that any distress becomes evident, we will encourage the participant to seek support or guidance. This may take a number of forms depending upon the nature of the distress or the concern. For example, we would provide the contact details of the contact person of the XXXAHS ethics committee (as outlined in the participant consent form) as an avenue for the participant to discuss any concerns related to the research process. If the

concern appears to be related to workplace events that have been discussed in the group discussion or interview, we would encourage the participant to discuss concerns with their manager or with the human resource services in XXXAHS. The participant may also be offered support from counselling or support services that are available.

In regards to maintaining confidentiality/anonymity

- It is true that staff who participate in the focus groups and workshops will be known to each other. At the start of any meeting or focus group that is being recorded staff will be told not to refer to each other by name.
- Ground rules will be set prior to data collection to ensure that those participating in the group discussion etc will not talk about what is discussed outside of the group.
- Steps outlined above will be used to ensure participants feel comfortable and safe to discuss their concerns.
- When reporting data from research participants I will use the identifiers 'midwife 1', 2 etc rather than their actual names. There will be no way of linking those who are interviewed separately with those participating in the focus groups or interactions occurring at meetings.
- The research participants who participate in the focus groups will be labelled as 'Midwife 1', 2 etc but in the reporting of these data, we will attribute any quotes to focus group 1 or focus group 2 etc depending on when they occurred.
- The majority of participants will be midwives. Managers, doctors and allied health staff who are interviewed will all be labelled as key stakeholders and de-identified.
- If a participant makes a statement that could mean they are easily identified by others because they often make that type of statement or use that expression – this quote will not be presented in the findings.
- Once the data has been coded, the process of analysis will facilitate integration and synthesis of the data. Once this has occurred, it will not be possible to identify which method of data particular quotes has come from.
- Participants will be given the opportunity to read the final report before publication and if there is any concern that a person could be identified, this will be addressed by either ensuring that a more appropriate non identifying label is used, removing the quote or embedding the point that is raised within the main text and not attributing the point raised to any particular participant.
- Evidence of approval from the midwifery unit manager

I have attached a letter of support from the postnatal manager.

Evidence of institutional approval should be provided (Q12b), particularly as the research would be undertaken in the workplace

- I have attached a letter of support from the Director of Nursing and Midwifery.

Evidence of ethics approval from XXX Area Health Service should be provided;

- I have attached a letter of approval from the XXXAHS Human Research Ethics Committee.

All participant information and consent forms should be on UTS letterhead as well or instead of XXXAHS letterhead, and contain contact details for the supervisors

- I have amended the participant information and consent forms reflecting UTS request

A copy of the Masters Assessment should be provided.

- I have attached a copy of the letter from Professor Elliot confirming my candidature assessment for your information and the documented submitted.

The Committee expressed concern that the potential outcome might be overstated to participants.

- Participants will be told that they as a group or individually may not gain any benefit from the research.
- Potentially, through this engagement with midwives, a new model of care will be developed. It is envisaged that the midwives who are instrumental in developing aspects of care will feel more satisfied professionally particularly if their work environment improves and they have had the opportunity to improve the quality of care currently provided to the women.
- Participating midwives may benefit by developing new skills, knowledge, and understanding. For some, this may lead to feelings of empowerment and greater confidence.
- The institution may benefit from the research as being able to provide women with improved options for care which may bring advantages to women..
- The women and their families may benefit from a new model of care, particularly if they receive increased individualised care. They will also be told that the research may not necessarily bring any benefits to them but the findings may assist other women receiving postnatal care. During the research there may be only small changes implemented. Even so, during the research, the midwives will have the opportunity to express their concerns and feel valued.
- My role as both student and employee might be confused, particularly given my position of authority.

There is a risk that as the researcher and midwifery consultant I might ‘blurr’ the boundaries between the employed hospital role and the research project role. This dilemma is well documented in action research projects. In sustaining an organisational role and research perspective simultaneously, action researchers are

likely to encounter role conflict and find themselves caught in boundaries of allegiances, behavioural claims and identity action dilemmas.

- I am very aware of my position both as researcher and as a staff member who carries some responsibility for policy development and education in the hospital. As the researcher, I am aware of the influence of my role on potential participants. During the research I will remain sensitive to this and not use this position to pressure or influence the staff to become participants. Maintaining respect for the dignity and well being of the research participants is the foremost consideration and this responsibility will take precedence over the benefits of the research.
- I will write field notes about my experiences of the duality of roles and regularly reflect on these with my supervisors to minimise the risk of this role confusion.
- As indicated above, it may be that the focus groups held at the end of the action research cycles are best facilitated by another person. When I do facilitate focus groups and meetings this will be done in a professional manner maintaining respect for the dignity and well being of the midwives, whose needs will take precedence over the benefits of the research.

Thank you again for considering this ethics application and please do not hesitate to contact me for further information.

Yours sincerely

Lyn Passant

UTS student 02005294
CC Professor Pat Brodie - UTS
CC Ass Professor Virginia Schmied – UWS

Appendix 3 – Participants Information sheet and consent form

INSERT UTS LOGO

PARTICIPANTS INFORMATION SHEET

What are the key strategies that enable midwives to develop a new model of postnatal care in an acute care setting?

The aim of this study is to design, implement, and evaluate a new model of postnatal care that responds to the needs of women, infants and families using the maternity services. The model will be designed to increase parenting skills and confidence, breastfeeding initiation and duration, women's knowledge of physical and psychosocial problems, and address job satisfaction of midwives.

This study will be conducted in phases and will use quantitative and qualitative methods to collect and analyse data and test the model of care.

In Phase One of the study, the researcher student from the University of Technology, Sydney will collect baseline data to describe and evaluate the current postnatal services. Focus groups with be conducted with midwives and interviews with key stakeholders across the Maternity Unit.

The aim of the focus groups are to explore midwives' perceptions of quality postnatal care and the 'culture' of the postnatal unit that influence the nature of care provided and the factors that facilitate or hinder this.

The focus groups and interviews will be conducted over one hour will be confidential and voluntary. As you have kindly devoted your time and support to the focus group research it is anticipated that you will be agreeable to completing the entire focus group data collection, which is expected to be no more than one hour. Leaving early will cause issues for the quality of the data and your obligation to complete the entire focus group is important to the research validity.

Demographic details will be collected in order to describe the group and any information which will identify individual participants will not be used. The focus groups will be tape recorded in order to validate interpretation. Direct quotes from the audio recordings will be used to illustrate the key points made by the group. The facilitator will be a Masters Honours student from the University of Technology Sydney she is also the Clinical Midwifery Consultant, with an assistant to transcribe.

Field Notes Data Collection

In Phase Two of the study, we will be actively engaging and working with midwives to design the new model of care. During this phase there will be opportunities for facilitation of action research groups. Data will also be collected from regular discussion groups and meetings, observations of midwives at work, workshops and in service sessions and any other opportunity that may arise with consent from the midwives. Participants from opportunistic and action research groups will be recruited prior to any meetings or forums.

You will be advised and aware of the opportunistic forums as they will be part of data collection. The researcher will provide you with a form to sign confirming you were made aware of the data collection period and process also acknowledging that the activity would be used in data collection via the researcher's field notes.

Midwives have expressed frustration with the service and it is timely and essential to design a model of postnatal care that meets the needs of women and families accessing services at the maternity unit.

We wish to thank the midwives and stakeholders who are actively participating in this exciting project.

ADD UTS LOGO

PARTICIPANTS CONSENT FORM

Focus Groups and Interviews

I _____ *(participant's name)* agree to participate in the research project: "What are the key strategies that enable midwives to develop a new model of postnatal care in an acute care setting?" (*UTS HREC approval reference number when obtained*) is being conducted by Lyn Passant, Faculty of Nursing, Midwifery and Health, University of Technology Sydney (UTS) PO Box 123 Broadway who is supervised by Professor Patricia Brodie her contact details are: pat.brodie@uts.edu.au Phone No: 95144822.

I have read the information sheet provided to me and I understand the aims of the study, I understand the focus groups and interviews will be conducted over one hour, will be confidential and voluntary. As a participant I understand I must not reveal any information shared during the focus group or disclose the identity of the participants outside of the focus group discussion. I understand by leaving focus groups early I may compromise the quality of the data therefore, I will be committed to complete the entire focus group.

I give consent to my demographic details to be collected in order to describe the group and any information which will identify me will not be used.

I am aware that I can contact Professor Patricia Brodie if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. I understand withdrawal from the research will not prejudice my employment or relationship with the maternity unit.

I agree that Lyn Passant has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signature (participant)

_____ ____/____/____

Signature (researcher or delegate)

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: 02 - 9514 9772, Research.Ethics@uts.edu.au), or Professor Patricia Brodie her contact details are: (ph: 9514 4822, pat.brodie@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

UTS LOGO

PARTICIPANTS CONSENT FORM

Field Notes Data Collection

I _____ *(participant's name)* agree to participate in the research project: "What are the key strategies that enable midwives to develop a new model of postnatal care in an acute care setting?" (*UTS HREC approval reference number when obtained*) is being conducted by Lyn Passant, Faculty of Nursing, Midwifery and Health, University of Technology Sydney (UTS) PO Box 123 Broadway who is supervised by Professor Patricia Brodie her contact details are: pat.brodie@uts.edu.au Phone No: 9514 4822.

I have read the information sheet provided to me and I understand the aims of the study, I understand field notes will be collected from opportunistic forums and I will be informed when any such data will be used. I understand that my participation in this research will be confidential and voluntary.

I give consent to my demographic details to be collected in order to describe the group and any information which will identify me will not be used.

I am aware that I can contact Professor Patricia Brodie if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. I understand withdrawal from the research will not prejudice my employment or relationship with the maternity unit.

I agree that Lyn Passant has answered all my questions fully and clearly.

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_____ ____/____/____

Signature (participant)

_____ ____/____/____

Signature (researcher or delegate)

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: 02 - 9514 9772, Research.Ethics@uts.edu.au), or Professor Patricia Brodie her contact details are: (ph: 9514 4822, pat.brodie@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 4 – Summary of the 'Brainstorming' workshop to design a new model of postnatal care

	STRATEGIES	PURPOSE/AIM OF STRATEGY	ACTIONS NEEDED TO IMPLEMENT	EVALUATION
ANTENATAL **Group 1.**	Multi-disciplinary meeting – ongoing regular review Midwifery clinic alongside consultant clinic for high risk women More access to MGP Build a postnatal care session before delivery suite tour Peer support Breastfeeding group	Maintain equal priority given to maternity services To ensure women have access to midwifery input More availability of continuity of midwifery care Increase preparation for postnatal period	Ensure data feedback to relevant areas Staffing Rooms availability Obstetric support	Evaluation Postnatal areas feel valued Awareness of issues coming up Clinical provision feedback form Breastfeeding rates Decision – support Better psychosocial outcomes
POSTNATAL – PARENTING ROOM **Group 2**	Comfortable room staffed by rotating staff (for example this could be someone who is working as a team coordinator and then from 10 am to 2pm staffs the parenting room or could be someone who starts at 10am or a bit earlier does the parenting room and then does MSP visits. Other options are to make use of other health care professionals/personal resources eg. LC ?? ABA on a Monday, Midwife student, use NGOs as a family support resource, ask CFHNs to staff for	To provide education and support To facilitate social interaction and peer support Increased social support To facilitate access to midwifery support when own midwife is occupied. To achieve an attractive, safe	Staffing Midwife could spend some AM time then do visits Team Co-ordinator (no pt load) LC (on a Monday) Adult education framework Comprehensive knowledge of infant	Room available Women using room Midwives happy with resource

		one morning a week	and comfortable environment. To relieve the burden of midwives – more time to focus on physical and psychosocial individual care.	care – transition to parenting Know referral pathways Facilitate group discussions "Talking up" by midwives Could have a focus on mothers who are here for the longer 5 day stay.	
POSTNATAL WARD **Group 3**		Individualise checks/care plans/no tick box Inquiring rather than telling self-caring Provide woman with information Focus on mothers, not visitors All staff shared values	Wellness model like at home. Philosophy of care – woman centred	Re think the care plan, tick box approaches Need prompts from women Booklet with a checklist Professional development in ward (in service) – consistent information	Mothers feeling confident Mothers satisfied
CONTINUITY OF CARE MODEL **Group 4**		Antenatal education set plan AIN re discharges similar to "day stay" Antenatal / P/N model – team – caseload Postnatal clinic	Normalise birth Include high risk Antenatal education set plan AIN re discharges similar to "day stay" Antenatal / P/N model – team	Staff education Liaise with community Access for women Community clinics with computer access Equipment	Evaluations Data/Stats Surveys of women and staff Key performance indicators Feedback

	Weekend ANC and postnatal 6 week postnatal care Link in with Child & Family Health – visit together – MW & Child and Family	– caseload Postnatal clinic Weekend ANC and postnatal 6 week postnatal care Link in with Child & Family Health – visit together – MW & Child and Family	Survey women re: sites Submissions/Funding	Increased BF rates Decreased re-admission Pre and post testing Child and family health nurse stats Increased women and midwife satisfaction.
MIDWIFERY AT HOME **Group 5**	Ward and MSP midwives doing some AN visits (group practice minus the birth) Review Families First intake process Revise criteria for MSP – more flexible, based on needs not < 48 hours. Not all visits – phone calls and more than 3 days Strengthening links with CFH Postnatal clinic with midwife and Child and family health nurses'	Continuity improved relationship and rapport Prepared women Better integration Close the gap between discharge and first visit More women with needs met MW attending PN groups with women Attend each others' team meetings Look at documentation and referral ? use the MSP form for all.	Identify the MW's (EOI) Meeting Planning Meet and review as a group Identify the problems Expand MSP Proposal for more staff or more flexible working conditions Implement and fund BR+ members NUM's to discuss and plan	Numbers Survey women Less phone calls to wards Less women with long gap to 1st visit Increased B/F rates New protocol More women on MSP Attendance at meetings

Appendix 5 - Description of Professional Development workshops organised for staff to attend

DESCRIPTION OF WORKSHOP	PRESENTER	NUMBER OF PARTICIPANTS
`Chatting': an important clinical tool in facilitating mothering in neonatal nurseries (1 hour)	Professor Jennifer Fenwick RN CM MNgSt	15
Ten Steps or Climbing a Mountain - Implementing BFHI in the hospital and community, Responding to women's needs in postnatal care, Postnatal Care: education and support (4 hours)		26
• Implementing BFHI in the hospital and community	Professor Fiona Dykes - Professor of Maternal & Infant Health, University of Central Lancashire	
• Responding to women's needs in postnatal care	Associate Professor Virginia Schmied University of Western Sydney	
• Postnatal Care: education and support	Lois McKellar - Midwife and PhD candidate, University of South Australia	
PEARLS of wisdom: promoting perineal comfort in childbirth (Blacktown) (3 hours)		6
• The PErineal Assessment and Repair Longitudinal study (PEARLS)'	Professor Debra Bick , Thames Valley University	
• Preventing perineal trauma and improving comfort	A/Prof Hannah Dahlen UWS	
• Experiences of midwives suturing after childbirth: a qualitative study	Julie Swain CMC, Prof Jane Cioffi & Fiona Arundell	
Workshop & Exploring what others have done and designing a new model (all day)		24
• 'Models of Postnatal care: the UK experience' (1 hour)	Professor Debra Bick UK	
• Rethinking Psychological screening in pregnancy and following birth.	Professor Jane Yelland, UK	
Postnatal care workshops (4 hours each x 6). • Demonstrate an understanding of women & family centred care • Develop skills, knowledge and attitudes to assist and support women and families during the postnatal period. • Enhance their knowledge of current evidence based practice in the postnatal period.	PD facilitators	32

• Develop value and belief statements that reflect the philosophy of the maternity care and staff in the postnatal period. • Strengthening models of collaboration in perinatal care	Professor Jane Yelland, UK	10
• Feedback from our research and exploring what others have done	Professor Virginia Schmied UWS Schmied, Elaine Burns, Lyn Passant	
Facilitating effective communication with women individually & in groups: Using a partnership framework (2X7 hours)	Paul Pritchard	22

Appendix 6 – Proposal for The New Model

Proposal for the Implementation of a New Postnatal Model of Care at Sterling Maternity Services

Prepared by Lyn Passant, Virginia Schmied and Linda Goulding

September 2008

Acknowledging the support of XXX (de-identified health service) in partnership with the University of Western Sydney in providing a grant to commence the project.

A NSW Health Innovations scholarship has been awarded in August 2008 for the evaluation phase of the project.

MEMBERSHIP OF THE STEERING COMMITTEE

Names removed	Professor of Midwifery UTS/XXXWAHS
	Associate Professor of Midwifery UWS
	Area Midwifery Educator
	Postnatal services co-ordinator
	Clinical Midwifery Consultant
	Clinical Midwifery Specialist
	xxxx Clinical Midwifery Specialist
	Clinical Midwifery educator

PURPOSE OF THIS DOCUMENT

This paper outlines a proposal for the implementation of a new model of postnatal care for xxx Maternity Services. The proposal has been informed by national and international research, State and Federal government policies and reports and local research that has collected and synthesised the views of midwives working in the maternity service and women from the xxx community.

It is proposed that a new model of postnatal care be implemented and evaluated in the latter part of 2008 and 2009. The new model is designed to respond to the needs of women, infants and families using the maternity services at xxx Hospital, to articulate with existing services such as Midwifery Group Practice models and the Child and Family Health Services, and to be cost neutral.

A two staged approach to the implementation of the model is proposed.

Stage 1 comprises the implementation of a series of strategies to increase the information that women receive about postnatal care and parenting in the antenatal period and to improve in-hospital postnatal care and support. This involves the development of a postnatal 'hand-held' resource for women, establishing a Parenting Room on the postnatal ward, staffed four hours a day by a midwife – parenting coordinator, and increasing midwives' communication skills. In stage 1 there will also be an increase in the number of women receiving midwifery care at home. This will be facilitated by rostering an additional two midwives to MSP each day / seven days a week. This will bring the total to 4 midwives providing home visiting. It is envisaged the midwives will share two cars initially and expanding the program will need a further car totally three cars.

In Stage 2 the new model of postnatal care will be implemented. This model of care is an **antenatal / postnatal community based model**. There will be a focus on providing continuity of care across hospital and home, and antenatal and postnatal services. The model is designed to increase parenting skills and confidence, breastfeeding initiation and duration, women's knowledge of physical and psychosocial problems, and address job satisfaction of midwives.

BACKGROUND

Having a baby is the most profound life event for women and the role of the midwife is to protect and enhance the health and social status of women (ACMI). Yet women describe the in-hospital postnatal care as the least satisfying experience compared to pregnancy and labour care and postnatal care at home (Cooke & Stacey 2003; Dykes 2005; Forster et al. 2006; Homer et al. 2002; McCourt et al. 2006; Renshaw et al. 2007). Woman also report difficulties with breastfeeding, a lack of confidence in parenting and there is a high occurrence of postnatal distress and depression (Brown & Lumley, 1998; Thompson et al, 2002; Cooke, 2000; Cooke & Stacey, 2003; Cooke et al 2003, Bick et al 2002).

Despite recommendations from government reports and research internationally and nationally, postnatal care remains inadequate and there is a prevalence of health problems after childbirth (Commonwealth of Australia, 1999; Department of Health, 2005; Renshaw, Rowe, Hockley, & Brocklehurst, 2007; Yelland J,

Krastev A, & S., 2007; Bick et al., 1997; S. Brown & Lumley, 1998; Cooke & Stacey, 2003; Dykes, 2006; Forster, McLachlan, Yelland, Rayner, & Lumley, 2005).

There have been limited attempts to implement initiatives to improve the current postnatal services. Reported barriers for midwives to provide quality care are numerous but overall midwives believe they do not have enough time to provide quality postnatal care. In part this has resulted from reduced length of hospital stay after birth, together with the increasing acuity and high levels of psychosocial needs of the women that remain in hospital (Yelland, Krastev, & Brown, 2007).

Recently however, Yelland et al (2008) have published the findings of a multi-component approach to improving postnatal care in three hospitals in Victoria. Their model included new ways of providing a more woman centred approach and addressed continuity of care for women by being flexible with rostering, facilitating evidence based information through the development of procedures and protocols, individualised antenatal planning of postnatal care, more consumer information and advice together with developing the midwives skills in managing postnatal issues and being able to be effective communicators. These strategies were effective in enabling skilled midwives to identify women who have the potential to develop health problems after birth and facilitated the targeting of appropriate services.

RATIONALE FOR THE NEW MODEL

Considerable research has been conducted in Australia and internationally which demonstrates that continuity of midwifery care through pregnancy, birth and the postnatal period is associated with improved clinical outcomes, increased satisfaction for women and cost effectiveness (Biro, 2000; Homer et al., 2001b; Homer et al., 2001a; Kenny et al., 1994; Rowley et al., 1995; Waldenström et al., 1998). There is also evidence that social support has long term positive effects on the physical and mental health of both women and their children (Oakley et al., 1990; Oakley et al., 1996). Continuity in the postnatal context has not been well developed. Setting up a model that provides the woman with continuity of midwifery care requires sustained preparation and support of staff by managers and leaders including a change in workplace culture (Homer, Brodie & Leap 2008).

McLachlan, Forster, Yelland, Rayner, and Lumley, (2008) suggest the current structures of inpatient postnatal care need to change. Standard postnatal documentation (clinical pathways) and fixed length of stay, may inhibit rather than support individualised care for women after childbirth. Greater flexibility in providing early postnatal care, including alternative models of service delivery; choice and flexibility in the length of stay after birth; a focus on the individual with far less emphasis on care being structured around organisational requirements; and building an evidence base to guide care.In addition, an ethnographic study by Dykes conducted in two maternity units in the UK suggests we need to reconsider the suitability of the hospital as the best place for postnatal care for healthy women (Dykes, 2005).

CONTEXT – xxx MATERNITY SERVICE

The NSW Mothers and Babies (2005) reported SSWAHS has the largest number of women giving birth across NSW. xxx and yyy Maternity Units recorded 2503 births in 2006 with a steady increase of approximately 200 births per year for the past four years. The increasing birth rate is putting pressure on

maternity services and means many women leave hospital within two days of the birth sometimes with little or no midwifery care at home. In 2004, average length of stay at xxx and yyy Maternity Unit was 2.5 and 2.8 days respectively (NSW Mothers and Babies 2005) with 40-50 percent receiving care at home.

A high proportion of women and infants living in the xxx local government area are vulnerable to poor outcomes and arguably, have greater need for midwifery support in the early postnatal period. Families living in this area have on average a lower income, are younger, and there are more single women giving birth compared to other Australian families (Australian census, ABS, 2006). Further, SSWAHS has the lowest rate of breastfeeding initiation in Metropolitan Sydney, and the second lowest in NSW (NSW CPHN 2003b).

In 2006 xxx and yyy Hospitals introduced two midwifery group practices to address lack of continuity of care. This model of care has been positively evaluated by women (Knight, Kemp, Brodie & Passant 2007).

POSTNATAL PROJECT - PROGRESS TO DATE

Phase One

Phase One of this project was undertaken between October 2007 and June 2008 and explored women's perceptions and experience of the content and quality of postnatal care at Campbelltown and midwives perceptions of what is quality postnatal care, the barriers to providing quality care and what would comprise an ideal model. Data were collected through focus groups and surveys. Field notes recorded data collected opportunistically from forums including ward meetings, workshops, in-services, and informal conversations.

A total of 197 women were recruited to complete a survey two weeks following the birth of their baby (in progress with an approximate 50% return rate). Five focus groups were conducted - with a total of twenty four midwives working at the Maternity Units and one focus group with the Child and Family Health Care Team.

Key Findings from the Focus Groups with Midwifery Staff

Midwives described what they believed women needed in the early postnatal period and the barriers to providing quality care.

Key elements of postnatal care - Midwives perceptions of what women want and need in postnatal care

- Education - to be prepared to care for their infant and themselves, particularly support with breastfeeding
- Support for social and emotional needs
- Flexible and individualised care
- Access to sensitive support and caring midwives
- Time to talk and be listened to by a midwife
- Rest

Women who participated in focus groups identified the following issues:

Key element of postnatal care – what women said they need

- More help and support breastfeeding
- Privacy
- Rest and recovery time (less visitors/interruptions)
- Make information about infant feeding and parenting issues easy to access (e.g. posters on walls)
- Autonomy
- Respect
- Not feel rushed – time for midwives to sit and listen
- Environment too busy and noisy
- Information about what to expect in the postnatal period (antenatal)

The midwives were asked to identify barriers to providing quality midwifery care to women on the ward. A summary is provided below:

Barriers identified by the midwives to providing quality care

- Not enough time to spend with women, just focus on being safe, no time for information sharing
- Women are isolated (behind curtains)
- Limited rest: too many visitors and too much noise
- Old equipment

Midwives identified strategies required to meet the needs of the women.

- Address postnatal expectations –preparation in the antenatal period
- Spend more time with women
- More support for student midwives
- Information and educational resources for women
- Increase the support given to breastfeeding
- Having a shared vision and working as a team
- Evidence base practice – updating and revising policies
- Collaborative model – working in partnership with women and across disciplines

Phase Two - Practice Development Activities and Strategies

Practice development commenced with the midwives in late 2007. The project team together with the clinical midwifery specialists are facilitating practice development by actively engaging and working with midwives and other staff to design the new model of care. Practice development strategies have included:

Professional / practice development strategies

- Regular professional development in-services
- Postnatal workshops to strengthen communication and develop a ward vision
- Workshops with International and National Experts
- Postnatal project meetings
- Developing evidence base guidelines using NICE guidelines (Demott K, et al 2006)
- Postnatal care workbooks
- Skills inventory

Model development

Midwifery managers, leaders and clinical midwives, predominantly from xxx, spent the morning with Professor Deborah Bick from Thames Valley University, London to explore new ways of strengthening postnatal care. The group of 24 participants explored five components of care:

- **Antenatal preparation** for all women - including strategies to engage women with limited access to midwifery care, for example, women receiving care from their general practitioner and women attending high risk medical clinics.
- **Providing more support for women and families whilst in hospital**: exploring the option of Parenting Room
- Making **postnatal care more woman centred and improving communication with women**
- **Effectively transitioning care** from hospital ward to community midwifery support program and to the child and family health care team.
- Facilitating increase in **midwifery care at home**.

The findings from Phase One and the practice development activities together with the outcomes from the recent workshop with Professor Bick have informed the development of the new model of care.

THE NEW MODEL

The information from the workshop, forums, focus groups and a literature review has been synthesised and has informed the proposed new model of care. The principles underlying postnatal care include:

- Continuity of care (across antenatal and postnatal)
- Building trusting relationships with women
- Early discharge option for more women
- Community based midwifery care following discharge close to where women live
- Flexible, individualised care including meeting needs for information and support
- Preparation for the early postnatal period during the antenatal period

- Providing consistent information that facilitates self-efficacy and confidence
- Spending more time listening to and talking with women about their needs and concerns (supported by the parenting room)
- Facilitate rest and recovery
- Facilitating women's individual needs

Stage One

Stage 1 comprises the implementation of series of strategies to increase the information that women receive about postnatal care and parenting in the antenatal period and to improve in-hospital postnatal care and support. This phase also focuses on preparing the midwives to work in new ways. Key strategies include:

- Scheduling either formal or informal information sessions for women on postnatal care during the antenatal period
- Developing a postnatal 'hand-held' resource provided for women in the antenatal period and used to guide women and midwives in their discussion of postnatal and parenting information
- Establishing a Parenting Room on the postnatal ward (staffed 3 to 4 hours a day ideally seven days a week)
- Strategies to reduce the length of stay for healthy women/baby including the promotion and preparation for early discharge earlier in pregnancy
- Increasing the number of women receiving midwifery care at home as it is envisaged there will be less women on the ward so midwives can be allocated to MSP
- Practice development of the midwives particularly focusing on midwives' communication skills

Engaging with women during the antenatal period

Through the development phase, midwives identified a number of strategies to facilitate information and support about postnatal care during pregnancy – (it is not necessarily the case that all strategies will be put in place).

Routine Antenatal Visits - Midwives to increase the amount of information provided to women about postnatal issues and early discharge during scheduled antenatal visits. Time is an issue identified by midwives but this could be supported by the use of a well designed resource (booklet or DVD). The information will incorporate a postnatal care plan. (Midwives need to priorities time for this).

Parenting Resource and Postnatal Care Plan - Midwives will develop an Information resource for women to keep – "hand held care plan" This will be modelled on work occurring in the UK and in South Australia.

Formal group education - A women's group session at 22 - 26 weeks gestation (invitation at booking and 20 week visit). The aim of the group would be to facilitate discussion with women about postnatal care and to support women in preparing a postnatal care plan. In the short term this could occur in the antenatal clinic (waiting room) but would ideally be conducted in a community setting.

Informal information sessions / discussions - Potential to adapt the existing waiting room in the out patients department (involving Preparation for Parenthood PFP) to be used as a group room to facilitate discussion on preparation for postnatal period, breastfeeding and early parenting. Discussion to be facilitated by a midwife / parenting coordinator for one hour a day during clinic times (see below for discussion of proposed role for midwife / parenting coordinator).

Engaging with women during the postnatal period

One of the essential elements of improving postnatal care is to increase the amount of time that midwives are able to spend with women discussing their individual needs and concerns. Midwives have identified a number of strategies related to the way in which they work with women that can accommodate flexibility in the care provided. One innovative strategy midwives would like to trial is the parenting / resource room.

Parenting Room

It is proposed that a Parenting Room be established on the postnatal unit. The Parenting Room will provide a place that women can access assistance if their allocated midwife is busy.

This parenting / resource room would be staffed by a dedicated midwife (for three to four hours a day) to provide women and their families' information to support parenting and infant feeding. The Parenting Room will provide the opportunity for women to interact with others and facilitate the possibility for women and family members to be involved in the group discussions. Antenatal women admitted to the ward will also have the opportunity to participate in the parenting room on the ward.

The midwife / midwives would not be rostered to work on the ward. Instead she will facilitate group education sessions both formal and informal around infant care, feeding, settling, bathing, self-care for mothers etc. The midwives will receive training in group facilitation and have expertise in infant feeding and early postnatal parenting skills. The child and family nurses may assist in group facilitation. Initially, we will trial the midwife spending three hours ideally every day in the parenting room and one hour in the OPD waiting room three days per week.

Increasing midwifery support at home

In stage one there will be an increase in the number of women who receive postnatal care in the community. This will be achieved by universal promotion of early discharge and postnatal midwifery care in the home as the norm for women and babies without complication. Currently around 40-50 percent of women receive care from midwives at home. An increase to 70-80 percent will require an additional two midwives per day to MSP. Currently there are two midwives allocated for Midwifery Support Program (MSP). The current MSP profile is two midwives each visiting 5-6 women per day, however, there are days when there is an overwhelming demand from women to return home and we are unable to provide them with the service. The proposed 'stage one' initiative will increase the number of postnatal community visits from 10 - 12 to 18-20 women per day, including phone calls and / or short visits for some women.

This can be achieved within the existing budget by being more flexible with rostering, staggering shift start times to cover the home visits from 0900 until sunset. Four midwives will be provided with three cars.

In summary, increasing midwifery support at home will address three issues:

- Increasing women's satisfaction with service
- relieving the current pressure on bed availability at xxx, and
- increasing midwives' confidence in providing community based care using the principles of primary health care[14]. This will prepare midwifery staff for the stage two of the postnatal project.

STAGE TWO – Antenatal / Postnatal Care in the Community a Midwifery Model of Care Ideal Model

In Stage 2 the new model of postnatal care will be implemented. This model of care will include **antenatal / postnatal care in the community with a number of midwives**. There will be a focus on providing continuity of care across hospital and home, and antenatal and postnatal services. This is a primary health care model designed to increase parenting skills and confidence, breastfeeding initiation and duration, and women's knowledge of physical and psychosocial problems. Importantly the model will also address job satisfaction of midwives.

This new model of care supports the commitment of providing primary health care. The core concept is continuity of care. In the new model, more midwives are involved in the woman's care compared to Midwifery Group Practices already established at xxx and yyy. The emphasis is on 'continuity of care' (a consistent team approach) rather than 'carer' (the same midwife).

The new model will subsequently be known as the 'community midwifery program' and will be a primary health care model situated in the community centres or hubs. Midwives allocated to the models will not provide labour and birth care. Initially it is anticipated that there will be two community based hubs, each allocated with 3 to 4 FTE midwives from the xxx Maternity Unit. The logistics will need to be explored following implementation of phase one. It may mean these midwives will provide antenatal and postnatal care for 600 women per year. In the future there would be four community based hubs caring for 1200 women per year.

The antenatal component in Stage two

- The antenatal care occurs in designated hubs located alongside the Child and Family Health Team (the outreach clinics in the local community including yyy Hospital). The model of care includes:
- Two 'Community midwives' would be required for 4 hours twice a week to provide antenatal care.

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[14] **Primary Health Care** incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health (Keleher, 2001).

- All antenatal care provided in collaboration with other health care professionals as required using the ACM guidelines for consultation and referral (ACM, 2008). Midwifery care, in collaboration with other professionals continues, and is based on the woman and baby's health care status.
- Preparation for postnatal care through use of personal plans for postnatal care.
- Midwives in hubs will either offer group information sessions in local area or will develop a model of group antenatal care. This could be done in collaboration with Child and Family Health nurses.
- The women understand the model of care from booking in and are expected to have the confidence to return home shortly after the birth with community midwifery care follow up.

The postnatal component

- The majority of postnatal care for well women will occur in their homes.
- Each day two community midwives will be rostered on the ward and are allocated to care for their identified women if they are on the ward.
- They will support the ward midwives by caring for women not under their care' if they do not have enough 'of a workload for that day.
- Handover between the midwives and the child and family team nurses will be strengthened to ensure a seamless transfer.
- If in principle support for stage 2 is given, then operational details will be further developed by the members of the Postnatal Steering Committee.

Evaluation

The evaluation includes a pre and post implementation survey of women. We can measure breastfeeding rates, midwives satisfaction and explore opinions and experiences of obstetric colleagues, Child and Family Health Nurses and midwifery managers. Measure key performance indicators including readmission, length of stay, numbers of home visits, improved handover from midwives to child and family health team (see attached innovations proposal).

Proposed Timeline

- Continue practice development opportunities with midwives in late 2008-2009.
- Establish the Parenting Room and trial 3 to 5 days per week Oct to January 2009
- Development of the antenatal groups in the OPD Oct to January 2009
- Training of interested midwives in facilitating groups will commence in September - October 2008
- Development of the 'hand held' information and care planner for women January – February 2009
- Development of Stage 2 for implementation in March 2009

Appendix 7 - The terms of references for both committees

The terms of references for the steering committee

1. To develop and implement an effective communication strategy to inform the community and key stakeholders about the changes occurring in the postnatal wards at Sterling and Alexandra Maternity Units.
2. To oversee and guide the implementation of the three phases of the research project and implementation of a new model of midwifery care in the postnatal wards at Sterling and Alexandra Maternity Units.
3. Consult with internal and external stakeholders to identify issues and develop solutions to address any barriers to successful implementation of the postnatal model. Evaluate the model and publish the process to share with other maternity units to be able to develop a similar model.

Membership

Professor of Midwifery UTS/XXWAHS

Associate Professor of Midwifery UWS

Area Midwifery Educator

Postnatal services co-ordinator

Clinical Midwifery Consultant

Clinical Midwifery Specialist

xxx Clinical Midwifery Specialist

Clinical Midwifery educator

The TOR for the working group

1. To create more effective work place for women and midwives in the postnatal ward at Sterling maternity unit
2. Develop a more women centred focus of care
3. Promote evidence based care for women and their babies,
4. Work collaboratively with colleagues to understand the barriers to providing improved care and eventually seek to change the situation
5. Work together to identify issues and barriers to providing quality midwifery care
6. Plan strategies to enable changes in work practices to occur, in consultation with all stakeholders
7. Action the initiatives
8. Evaluate the short and long term gains / changes

9. Reflect on the change for women and midwives

Membership

Area Midwifery Educator

Clinical Midwifery Educator

Clinical Midwifery Consultant

Clinical Midwifery Specialists

Clinical Midwives

Postnatal services manager

Appendix 8 - A summary of the short and long term suggested changes

POSTNATAL PROJECT – SHORT TERM GOALS

Identified issues	Strategies	Progress
Women needing more support especially women experiencing traumatic birth (C/S, stillbirth)	Open visiting, relative/loved one stay in overnight to assist	Risk assessment and guidelines developed
Partners not involved in the care /parenting		Implemented 2008 and continues
Midwives busy – doing non midwifery tasks E.g. answer visitor inquiry, security bell (out of visiting hours)	Identify non midwifery duties then train / delegate non midwifery duties to others i.e. EEN computer discharge summary, supporting women following C/S for a shower in am, make beds. Open visiting hours 0800-2000	Discussion occurred with EEN not implemented
Women and midwives feel women not prepared to take baby home as they lack confidence.	Resource folders in lockers in each bed room for the women / family	Attach to the bedside lockers late (2010).
Providing information.	Utilisation of the NSW Health “Having a Baby” booklet given in the antenatal period	Not implemented
Providing information.	Cork boards for displays for information / packs they can take what they need	Not implemented

Identified issues	Strategies	Progress
	NSW Health fact sheets added to desk top on workstation computer terminals	Attended
	Printed and available to women at the bedside	Not Implemented
Providing information.	Orientation pamphlet	Developed and printed
Providing information.	TV channel for education sessions	Not implemented
Providing information.	Daily group sessions with women – women set the agenda, woman-centred care approach.	Trialled - Not implemented
Administrative issues – double handling	Folders arrive from birthing unit clerical support organises in appropriate order. After hours midwives can attend.	Not implemented
Reduce noise on ward - Women buzzing for non urgent issues, loud voices of staff, no rest and recovery on the ward	Working towards a quiet time from 0600-0800.	Not implemented
	Explore with cleaners, midwives, catering how to encourage this quiet time.	Cleaners aware – however they need to mop early as there is less traffic.
	Lights low until 0800	Empty bins later in day.
	No entry into rooms until 0800 (unless required)	
	Cleaners to mop with floor lights only (no	

Identified issues	Strategies	Progress
	unnecessary talking)	Light switch ID labels
	Midwives to attend handover in the treatment room	Implemented
	Women to received their breakfast last rather than at 0710	Not implemented
Evidence-base practice	Update procedures for routine postnatal care	Developed and implemented
Professional development for the midwives	Weekly ward open forums (Wednesday lunchtime)	Workshops for all staff focusing on a values clarification statement for the ward
	Weekly multidisciplinary forums (lunchtime)	Challenging the usual ways we do things – moving to a new approach to the postnatal check.
		International and national guest speakers invited to share experiences with us

POSTNATAL PROJECT – LONG TERM GOALS

Identified	Strategies	Progress
Providing information. What to expect discussions in the parenting room.	Daily group sessions with women – women set the agenda, woman-centred care approach. Utilising the parenting room within existing budget. Explore each midwife inviting her allocated women to the room for 30 minute take the care planner and do the check (physical check in room)	Discussed with midwives following a workshop. Midwives try see if feasible?
Well women home on midwifery support, women at risk stay in	Philosophy of home idea place for postnatal care. More midwives working on MSP	Not implemented
Bed management issues – no midwifery led D/C	Midwifery initiated discharges all interested get accredited. ?neonatal midwifery initiated D/C	Not implemented
Ideally need more information during the pregnancy Midwifery model of care	Develop a continuity of midwifery care model antenatal and postnatal only. Community clinics. May address staff retention, more satisfied professionally.	Proposal endorsed by GM and DN&M

Not enough time to provide women with the information they need.	Staff issues Issues with limited clinical midwifery educator support. External advertisements 2008 some applicants.	Unsuccessful funding issues
Update procedures for routine postnatal care	Provide the midwives with evidence based procedures.	Uncomplicated caesarean section care Well vaginal birth woman Well neonate
Women not involved in their own care.	Handover at the bedside.	Barriers to implementation Skill and confidence issues
Re-evaluate team leader role to manage the interruptions, not allocated specific women. Focus on the complex BF issues, management etc	Work with colleagues to develop a new job description	Not implemented

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