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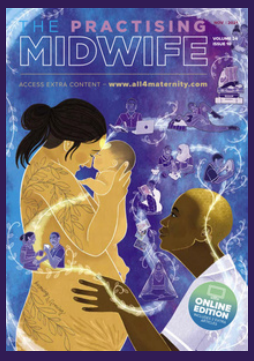
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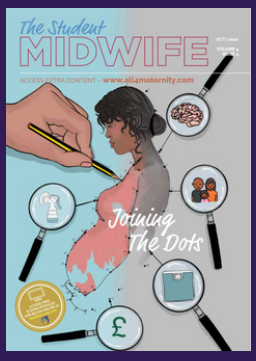
Neesha Ridley (FHEA)



Hannah Tizard (FHEA)







Contents

WEBINAR 1 - TRANSFORMING MIDWIFERY EDUCATION: THE FINAL STAGE OF THE FUTURE MIDWIFE PROJECT
PROFESSOR MARY RENFREW (PROFESSOR OF MOTHER AND INFANT HEALTH AT THE UNIVERSITY OF DUNDEE AND LEAD ADVISER TO THE NURSING AND MIDWIFERY COUNCIL FOR THE FUTURE MIDWIFE PROJECT)

WEBINAR 2 - MECHANISM OF LABOUR – THE INTERACTION BETWEEN THE MATERNAL PELVIS AND FETAL SKULL
ELAINE UPPAL (SENIOR LECTURER (TEACHING AND SCHOLARSHIP) IN MIDWIFERY AND PATHWAY LEAD MIDWIFERY MSC ADVANCED PROFESSIONAL PRACTICE AND LEADERSHIP AT THE UNIVERSITY OF MANCHESTER)

WEBINAR 3 - PARENT EDUCATION SERIES – PART 3: THE BIRTH AND BEYOND POSTNATAL PROVISION
NATALIE VAN ROOYEN (SHE/HER) – SPECIALIST PARENT EDUCATION MIDWIFE, ROYAL SURREY HOSPITAL, CAROLINE COUSENS (SHE/HER) – SPECIALIST PARENT EDUCATION MIDWIFE, ROYAL SURREY HOSPITAL

WEBINAR 4 - OPERATIONALISING DOMAIN 4: ADDITIONAL CARE FOR WOMEN AND NEWBORN INFANTS WITH COMPLICATIONS
ANNA MADELEY (SENIOR LECTURER - UNIVERSITY OF BEDFORDSHIRE)

WEBINAR 5 - HOW DOES WITNESSING A POSTPARTUM HAEMORRHAGE AFFECT PARTNERS' EMOTIONAL AND PSYCHOLOGICAL WELLBEING?
HAZEL CHARD (REGISTERED MIDWIFE)

WEBINAR 6 - THE DILEMMA OF MEDICATION AND BREASTFEEDING FOR STUDENT MIDWIVES
DR WENDY JONES MBE (PHARMACIST WITH SPECIAL INTEREST IN THE SAFETY OF DRUGS IN BREASTMILK)

WEBINAR 7 - CULTURAL SAFETY IN MIDWIFERY PRACTICE – PROTECTING THE CULTURAL IDENTITY OF THE WOMAN
SARAH ESEGBONA-ADEIGBE (SENIOR MIDWIFERY LECTURER- LONDON SOUTH BANK UNIVERSITY)

WEBINAR 8 - PROFESSIONAL MIDWIFERY ADVOCACY IN HIGHER EDUCATION: AN EVALUATION OF AN INNOVATIVE IMPLEMENTATION OF THE A-EQUIP MODEL
NATASHA CARR (SENIOR LECTURER, MIDWIFERY COURSE LEAD AND LEAD PMA)

TRANSFORMING MIDWIFERY EDUCATION:

THE FINAL STAGE OF THE FUTURE MIDWIFE PROJECT

Midwifery in the UK is at a crossroads. It is a vital time for the profession, and the women, their babies, families and communities who rely on midwives. That is why the NMC's Future Midwife project – a radical review and rewrite of midwifery education standards – is so important. In this opening article of a new series of Advancing Practice that follows the launch of the new standards and tracks their implementation, Professor Mary Renfrew, Lead Adviser to the NMC for the Future Midwife project, tells the story of how the standards have been developed, informed by best international evidence and by the participation of thousands of individuals and organisations.



> AUTHOR

Professor Mary Renfrew
Professor of Mother and Infant Health at the University of Dundee and Lead Adviser to the Nursing and Midwifery Council for the Future Midwife project

INTRODUCTION

What do all midwives in the UK need to know and be skilled in, now and in the coming decade?

This short but key question is at the core of the NMC's 'Future Midwife' project.

The midwifery profession has been on a long – and sometimes tumultuous – journey in all four countries of the UK.

- Technological developments have brought benefits, but also challenges as some interventions have become routine rather than used only when needed.
- Media criticism of the promotion and protection of women's physiology, especially birth and breastfeeding, has helped to foster a negative view of normal reproductive processes.
- Population health profiles, demographics, and social circumstances are changing, resulting in an increase in clinical, psychological, and social complications. Workforce shortages mean that many midwives struggle to provide the care that they know women need. High profile failures in care have shown that quality care is not consistently provided.
- At the same time, examples of excellent and innovative midwifery practice struggle for recognition, despite evidence of their success.

Significant change is needed – both to ensure midwifery care here remains among the best and safest in the world, and to strengthen midwifery education further, to enable all midwives to consistently provide the evidence-informed care that women, babies and their families want and need.

We know that new evidence shows the scale and scope of the impact that midwives have – skilled, knowledgeable and compassionate midwifery care has a huge impact on outcomes and experiences for women and babies, and is fundamental to quality maternity care.

We also know that, on the rare occasions when things go wrong, the consequences can be life changing.

So, in developing the new education standards that set the bar for the knowledge and skills that all midwives need when they qualify, the Future Midwife team knew we had to be radical. It was not enough to revise the existing standards – we had to use the opportunity to re-think what women, babies and families need, and what midwives must know, and be able to do.

After 18 months in development, the 12-week consultation on the Future Midwife draft standards was a vital opportunity to hear views on our work. The consultation was conducted by an independent company, with lots of awareness raising and encouragement for organisations, the public, midwives, educators and other professionals to participate.

In May, the consultation was completed, with more than 1,600 people and organisations responding formally and thousands more getting involved at events and online.

Behind every response to the consultation, there is a unique story and important evidence – and the depth and breadth of the responses we received is testament to just how much midwifery matters in the broad context of health and social care in the UK.

That's why it is vital that we get these standards right.

HOW WE GOT HERE

Following my appointment as Lead Adviser to the Future Midwife project in 2017, a thought leadership group (TLG) was formed to bring together midwifery and maternity experts, students, other health and care professionals and service-user representatives.

This group has met 10 times so far (and its virtual counterpart has met five times) to inform the draft of the new standards in a methodical, iterative process by building consensus and identifying areas of debate along the way.

All of these meetings were informed and shaped by our active external engagement across the four countries of the UK, with hundreds of women, families, midwives, educators, students, charities, advocates, other health-and-social-care professionals, and many others. The work was fully informed by an extensive set of reviews of best evidence, current policy, and learning from key reports.

"Significant change is needed to strengthen midwifery education further, to enable all midwives to consistently provide the evidence-informed care that women, babies and their families want and need"





PRACTICE CHALLENGE 1

What will be the main challenge of implementing the new education standards?

This was the context in which we drafted the new standards.

It is very important to be transparent and open to review and challenge, which is why all the work on the draft standards passed through the TLG and on to the NMC's Midwifery panel – a straight-talking group of experts and representatives from across the midwifery and maternity community, as well as service-user representatives.

The draft standards were approved by the NMC for consultation, which ran from 12 February – 9 May 2019. The Future Midwife team then received the report from the independent company, including a summary and details of all the responses to the consultation.

It is a real privilege to have received so many different kinds of responses from a wide range of people. It is essential that these voices are heard, and we have been working hard to learn from what people have said, to honour this input, and to make the final draft as good as it can possibly be.

The final version of the standards will soon be considered for approval by the NMC – then they will be available for universities to start work on preparing new curricula, and the work of implementing them in practice will begin.

THE GLOBAL CONTEXT

The midwifery profession is experiencing an exciting global spotlight, with the landmark World Health Organization (WHO) report: *Strengthening quality midwifery education for universal health coverage 2030* (WHO 2019), and with 2020 being celebrated by WHO as the Year of the Nurse and the Year of the Midwife.

So we need to learn from and contribute to the bigger, international picture.

We have mapped the standards to the International Confederation of Midwives (ICM) competencies, and we draw on the ICM definition of the midwife.

We plan to share with international colleagues our pioneering approach to developing national standards. Key to this has been the combination of applying global evidence to a national context, together with active input from thousands of people and organisations – a real example of evidence-informed coproduction.

THE STANDARDS – A NEW, RADICAL APPROACH

The Lancet series on midwifery (Renfrew et al 2014; Homer et al 2014; van Lerberghe et al 2014; ten Hooper-Bender et al 2014) was central to designing the structure and content of the new standards – using the best current evidence for quality maternal and newborn care.

This series provided an evidence-informed definition of midwifery and a framework for quality care that firmly places the needs of women and their newborn infants at its centre, and uses a human rights approach to ensure skilled and knowledgeable care for all (Renfrew et al 2014). We have used these principles throughout the standards.

PRACTICE CHALLENGE 2

How can midwives working in practice settings support their implementation?

UNIVERSAL CARE, AND ADDITIONAL CARE WHEN NEEDED

The Lancet series on midwifery showed that *all* women, babies and families need quality midwifery care: and that *some* women, babies and families with complications or further care needs need *extra* care – both midwifery care and multi-professional care. This has informed the concepts of universal care and additional care that are fundamental to the new standards and described in Domains 3 and 4.

This means that all women and babies should receive midwifery care that optimises normality, promotes their own capabilities and prevents complications.

All midwifery care should be both respectful and compassionate, and all midwives should recognise, respect and advocate for women's individual needs and preferences. All women should be enabled to make evidence-informed decisions. Unnecessary interventions should be avoided.

Crucially, this means that women, babies and families with complications or further care needs should not miss out on the invaluable universal midwifery care.

For example, if a woman gives birth by caesarean section – whether elective or emergency – she and her baby should not miss out on skin-to-skin contact and the opportunity for early breastfeeding, or for high-quality postnatal care, because we know from the evidence that this is best practice and should be universal.

It also means that for women and babies who develop complications, whether clinical or psycho-social, good multi-professional working – with quality midwifery care, and the midwife ensuring ongoing coordination – is needed to ensure that women and babies receive all the care that they need when they need it.

CONTINUITY OF CARE

The fundamental importance of continuity of care and of carer is recognised in Domain 2: the midwife's ability to provide and promote continuity of care and carer. Evidence shows that continuity promotes both safety and a favourable experience, and improves overall quality of care and outcomes (Sandall et al 2016). The woman's experience of care during her journey through pregnancy, birth and beyond, and care during the early life of her baby, should be seamless.

This domain recognises that the midwife plays the key role in continuity across the whole continuum of care, and in all settings – community, midwifery-led unit or hospital. Whether that journey is straightforward, and care by one midwife is all that is needed, or whether there are complications and other professionals are needed too, the midwife is central to ensuring that the woman and baby's needs and preferences are understood and met.

THE MIDWIFE – ACCOUNTABLE, AUTONOMOUS: COLLEAGUE, SCHOLAR, LEADER

Two of the Domains recognise the essential qualities of all midwives – Domain 1: Being an accountable and autonomous midwife, and Domain 5: Promoting safe and effective care: the midwife as colleague, scholar and leader.

Throughout the engagement and consultation stages of this work, it was crystal clear that core midwifery skills include communication, advocacy, respect, compassion and kindness, multiprofessional working, and understanding and using evidence.

Captured in these two domains are the qualities that will ensure that midwives provide the best quality care for all women and babies, respecting individual circumstances and needs, providing evidence-based information when appropriate, and advocating effectively for women when needed.

Learning does not stop on qualification. Qualified midwives will have the tools to develop their knowledge and skills over time. All midwives must be able to find and use evidence to stay current, address new challenges, and ensure that they are using best evidence to inform their care.





Midwives should have the skills to play a full part in multi-professional teams. To ensure high-quality care, they will need to contribute to ensuring safe systems, communicating effectively with colleagues as well as with women and families; escalating concerns when necessary; and supporting and enabling colleagues and students to give of their best. They will need strength and flexibility to deal with the inevitable challenges of working in midwifery and maternity care.

These qualities are essential for safe and effective care wherever midwives work. They are also needed to help these standards to stay relevant. The standards will be in place for the coming decade, and new challenges – new diseases, new technologies, changing social contexts – will undoubtedly emerge. Future midwives need to be able to learn, develop and adapt, as knowledge and circumstances change.

Some have said that the draft standards set the bar too high. What we have heard during our engagement and consultation, and what we know of the evidence, however, shows us that women, babies and families need all midwives to have these qualities, and this full spectrum of knowledge and skills – and that they will form a strong foundation for ongoing, lifelong learning.

WHAT'S NEXT?

This is a very brief description of how these standards – once they are finalised – can have a real, positive impact on the care that women, babies and families receive.

The revised version of the standards will be considered by the NMC at its October meeting. If the Council approves the standards, the final versions will be ready by November. We know that it is vital that Lead Midwives for Education and others involved in designing curricula have the time to plan and quality-assure their programmes. We know that midwives who will be supporting students in practice will need to consider whether changes will be needed to provide the best possible learning environment.

We are grateful to have had such positive input into this journey so far. We are looking forward to the implementation of these standards that so many people have helped to shape and that will enable midwives to provide the best possible care for all women, babies and families.

The new standards will be formally launched in each UK country early in 2020: an ideal time to mark and celebrate the Year of the Midwife. **TPM**

> *"Learning does not stop on qualification. Qualified midwives will have the tools to develop their knowledge and skills over time"*

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Chapter summary

Key learning points

ARTICLE OF THE MONTH
Lead article each month, taking you from the journal to the website for a module on the subject.

This month:
Mechanism of labour – the interaction between the maternal pelvis and fetal skull.

Go to the module at www.practising midwife.co.uk

Try out our sample questions on page 13 then go to the website to complete the module and gain a certificate for your revalidation portfolio



Elaine Uppal
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Mechanism of labour – the interaction between the maternal pelvis and fetal skull

❒ Go to **www.practisingmidwife.co.uk** to read an expanded version of this article, including long and short rotations

This article considers the anatomy and physiology underpinning the mechanism of labour in terms of the amazing journey the fetus completes through the maternal pelvis. In order to monitor maternal and fetal wellbeing and promote progress in labour, the midwife needs a thorough understanding of: the maternal pelvis, the external structure of the fetal skull, and how the presentation and attitude of the fetus determines the presenting diameter of the skull.

COMPOSITION OF THE PELVIS

Knowledge of the anatomy of the maternal pelvis is crucial in understanding the normal mechanism of birth, detecting any deviation from the norm and making appropriate referrals to ensure maternal, fetal and neonatal wellbeing (Nursing and Midwifery Council (NMC) 2012; 2015).

The pelvis consists of four bones which articulate at four joints: the sacrum, formed by the fusion of five sacral vertebrae at the rear of the pelvis; the coccyx, formed by the fusion of four originally separated coccygeal bones, forming the bony base of the spinal column and pelvis; and two innominate bones which form the sides of the pelvis. The innominate bones are further divided into three parts: the ilium, ischium and pubis (as shown in

Figure 1 **Anterior (front) view of female pelvis**

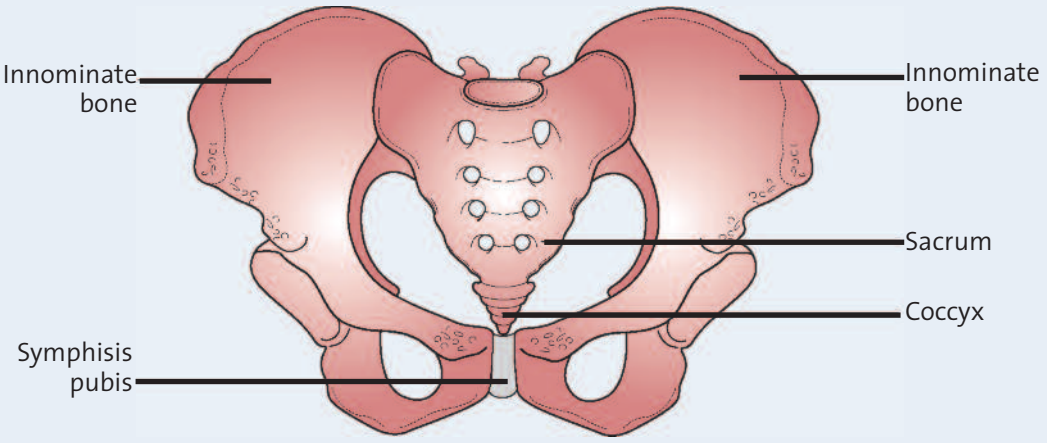


Figure 2 **Superior view of the pelvis to show the landmarks of the pelvic brim**

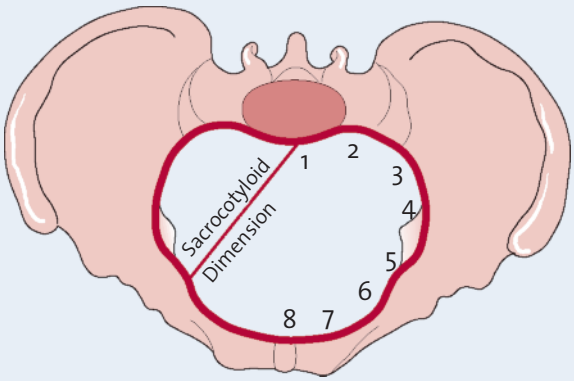


Figure 1). These bones all meet in the acetabulum, with the fossa forming the socket for the hip joint.

REGIONS OF THE 'TRUE' PELVIS

The false (greater) pelvis is larger and superior (above) to the true (lesser) pelvis where the pelvic inlet is located. The greater pelvis is deemed to be located abdominally, whereas the true pelvis contains the rectum, bladder, uterus and vagina. There are three sections of the true pelvis: the brim; cavity; and outlet through which the fetus rotates and descends utilising the largest diameters.

PELVIC BRIM

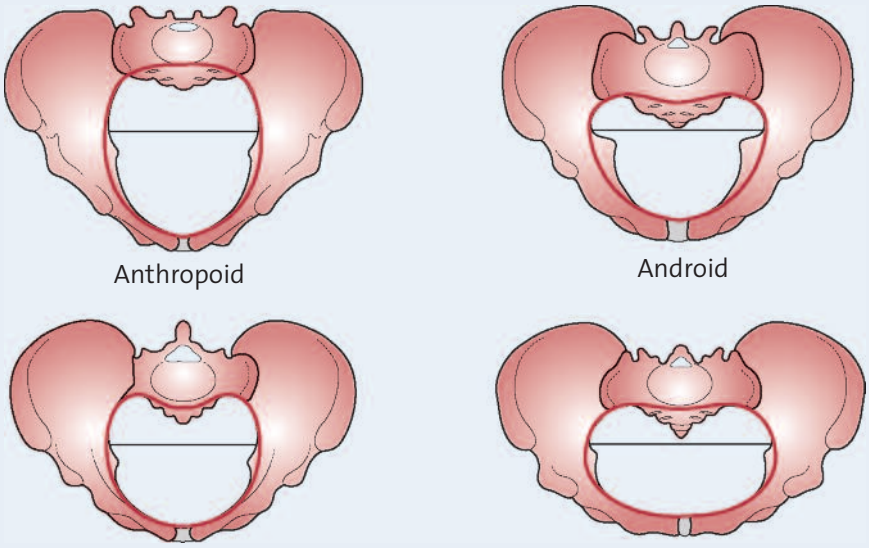
This is oval in shape as the anteroposterior diameter is reduced by the sacral promontory. Starting from the centre of the sacral promontory and tracing the brim around to the symphysis pubis (see *Figure 2*), the eight points or landmarks comprise:

1. Sacral promontory
2. Front aspect of the ala of the first sacral vertebrae, also known as sacral wing of ala
3. Upper border of the sacroiliac joint
4. Iliopectineal line
5. Iliopectineal eminence
6. Upper inner border of the superior pubic ramus
7. Upper inner border of the body of the pubis
8. Upper inner border of the symphysis pubis.

PLANES, ANGLES AND INCLINATION OF THE PELVIS

When standing upright, the pelvis is naturally tilted; the mathematical terms 'angles' and 'planes' are applied to indicate the direction of the slopes of the pelvis: an angle occurs where two rays represented by lines meet a common endpoint; whereas a plane >>>>

Figure 3 **Pelvis shapes**



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Figures 4 and 5 **The pelvis, showing the degrees of inclination: inclination of the pelvic brim to the horizontal, 55°; inclination of pelvic outlet to the horizontal, 15 °; angle of pelvic inclination, 135 °; inclination of the sacrum, 90 °**

Figure 4

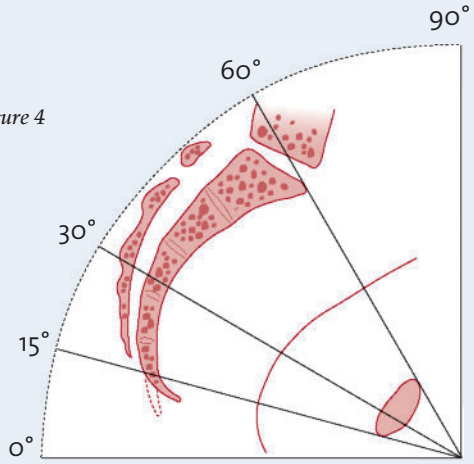
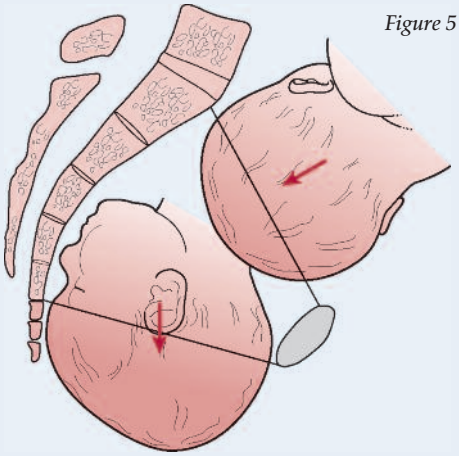


Figure 5

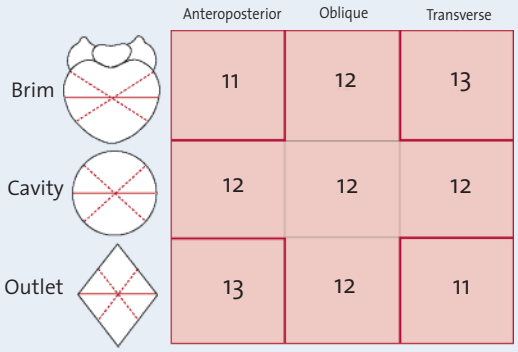


comprises the relationship between the pelvis and a flat surface such as the floor – or imagine a piece of paper being placed across the landmarks to form a flat surface. The fetus must negotiate the changing angles of the pelvis as it descends through the brim and emerges through the outlet, following the curve of carus as it descends and rotates. There are various types of pelvis: gynaecoid (50 per cent); android (25 per cent); anthropoid (25 per cent); and platypelloid (less than 5 per cent incidence), shown in *Figure 3*.

ENGAGEMENT AND DESCENT OF THE FETAL HEAD THROUGH THE PELVIS

The ischial spines of the pelvis are designated station 0; when the head is above them, it is said to be -1, -2, -3 or -4. If the head is below the level of the ischial spines the station is +1, +2, +3 or +4. If the head is at the level of the ischial spines, this is classed as cephalic engagement as it is situated in the true pelvis. The widest diameters of the pelvis are transverse in the brim and antero posterior in the outlet (as illustrated in *Figure 6*).

Figure 6 **Normal pelvic diameter measurements**



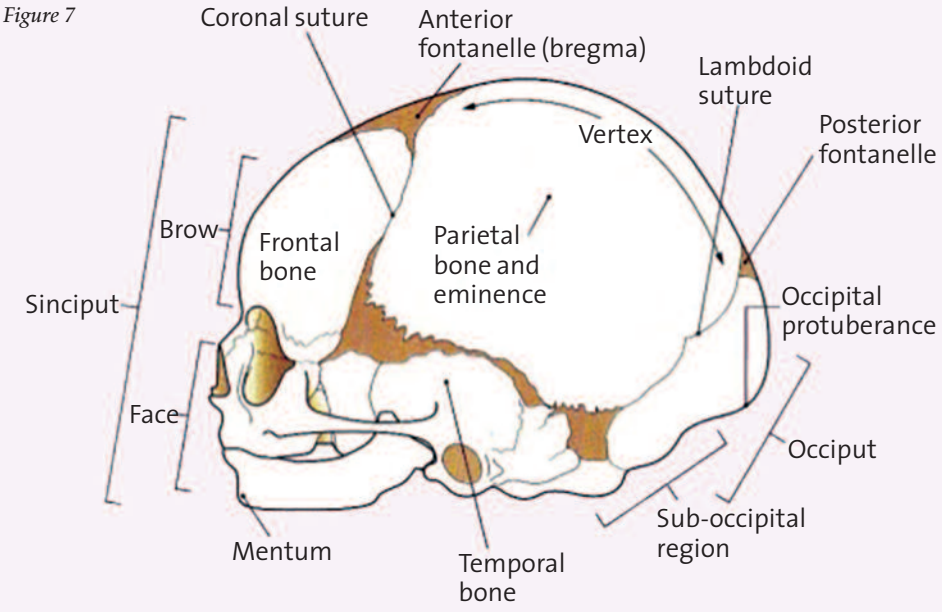
FETAL SKULL

The fetal skull provides a key partnership with the maternal pelvis that is crucial to the success of the mechanism of labour. It is imperative to be able to determine the structures, regions, landmarks and diameters of the fetal skull and understand how this knowledge enables midwives to: recognise normal presentations and positions of the fetus; and detect any deviations from the norm in order to address potential complications that can occur during the birthing process (NMC 2012; 2015). The fetal skull comprises: a vault – with two frontal bones, two temporal bones, two parietal bones, one occipital bone – the face; and base. The lambdoidal suture lies between the occiput and the parietal bones; the sagittal suture runs from the anterior to the posterior fontanelle, dividing the parietal bones; the coronal suture separates the parietal from the frontal bones; and the frontal suture divides the frontal bones. The vertex is bound by the anterior fontanelle (kite-shaped bregma), posterior fontanelle (Y- or triangular-shaped lambda) and the two parietal eminences (see *Figure 7*).

ASSESSING THE POSITION OF THE FETUS

Left occipito anterior (LOA) – posterior fontanelle anterior to the left, sagittal suture is in right oblique
Right occipito anterior (ROA) – posterior fontanelle anterior to the right
Right occipito posterior (ROP) – anterior fontanelle anterior to the left
Left occipito posterior (LOP) – anterior fontanelle anterior to the right
Left occipito lateral (LOL) – posterior fontanelle to the left
Right occipito lateral (ROL) – posterior fontanelle to the right

Figure 7



Occipito anterior (OA) – posterior fontanelle felt anteriorly
Occipito posterior (OP) – anterior fontanelle felt anteriorly

MECHANISM OF LABOUR

This requires consideration of the: power – in terms of the strength and regularity of contractions; passage – in terms of the pelvis; and the passenger – in terms of the fetal position and flexion of the head. These combine to facilitate progress in labour.

DEFINITIONS OF TERMS

Lie – This is determined by the relationship between the long axis of the fetal spine and the long axis of the maternal uterus (longitudinal, oblique or transverse).

Attitude – The relationship of the fetal head, spine and limbs to its body (fully flexed, poorly flexed, deflexed or extended).

Presentation – The part of the fetus lying lowermost in the birth canal (cephalic, breech, face or brow presentation).

Position – The relationship between the denominator and the mother's pelvis (LOP/ROP or LOA/ROA).

Denominator – A fixed point on the presenting part that relates to position (occiput [back of head], sacrum [buttocks], mento [chin]).

Engagement – When the head passes through the brim of the pelvis.

DIAMETERS OF THE PRESENTING PART

SOB – Sub occipital bregmantic 9.5cm – relates to OA position, extending from the nape of the neck to the centre of the anterior fontanelle. The attitude is complete flexion and the presentation vertex.

SOF – Sub occipital frontal 10cm – relates to OP position undertaking long rotation and returning to OA position, extending from the nape of the neck to the centre of the frontal suture. The attitude is incomplete flexion and the presentation is vertex.

OF – Occipito frontal 11.5cm – relates to OP position undertaking short rotation and remaining in OP position; it extends from the occipital eminence to the bridge of the nose (glabella). The attitude is marked deflexion and the presentation is vertex.

MV – Mento vertical 13.5cm – relates to brow presentation (the point of the chin to highest point of the vertex). The attitude is midway between flexion and extension and the presentation is brow.

SMV – Sub mento vertical 11.5cm – relates to brow presentation (where the chin joins the neck to highest point of the vertex). The attitude is incomplete extension and the presentation is face.

SMB – Sub mento bregmatic 9.5cm – relates to face presentation. It extends from the junction of the floor of the mouth and neck to the centre of the bregma. The attitude is complete extension and the presentation is face.

>>>>

Mechanism of labour left occipito-anterior (LOA)	
Lie	Longitudinal
Presentation	Vertex
Position	Left occipito-posterior
Attitude	Flexion
Denominator	Occiput
Engaging diameter	Sub-occipito bregmatic – 9.5 cms
Descent	Takes place with increasing flexion of the fetal head, the occiput becomes the leading part.
Internal rotation (head)	The occiput meets the resistance of the pelvic floor and rotates anteriorly an eighth of a circle. There will be a slight twist in the neck now, as the shoulders are still held OA. This means that the head will be able to emerge through the widest diameter of the outlet.
Crowning	By a movement of flexion, the occiput passes over the perineum and the head is crowned (it no longer recedes because the largest diameter has been born).
Extension	The sinciput, face and chin escape under the symphysis pubis, sweep the perineum and the head is born by a movement of extension.
Restitution	The occiput turns an eighth of a circle to the right to realign itself with the back and shoulders.
Internal rotation (shoulders)	The shoulders enter the pelvis in the left oblique diameter, the anterior shoulder meets the resistance of the pelvic floor and rotates an eighth of a circle to lie under the symphysis pubis the AP diameter.
External rotation	At the same time, the occiput turns a further eighth of a circle to the right as the head is now free, it is seen to rotate externally as the shoulders do simultaneously inside. The head will always rotate in the direction expected from the position of the fetal back.
Lateral flexion	The anterior shoulder escapes under the symphysis pubis, the posterior shoulder sweeps the perineum and the body is born by lateral flexion, following the curve of carus.

MECHANISM OF LABOUR – OCCIPITO ANTERIOR POSITION

The fetus is round-shouldered, with head flexed and chin on chest. The rounded back bulges forward into the soft maternal abdomen. In labour the ovoid shape fits the lower uterine segment and presses evenly on the cervix, stimulating good uterine contractions and facilitating dilatation of the cervix. The smallest possible diameters stretch the pelvic floor and perineum and the fetal head is moulded in the most favourable diameter.

CONCLUSION

The pelvis is a major bone in the body comprising a complex framework; it is vascular, consisting of bone, ligaments and nerves which all facilitate upright movement. The pelvis plays an important part in protecting the internal soft organs and in aiding normal childbearing to facilitate the passage of the fetal skull and body in a complex series of mechanisms in order to be born. Midwifery care is crucial to ensure progress in labour and support the woman during the childbirth continuum. Key identifiable features for midwives on vaginal examination include: suture lines; fontanelles – bregma (anterior fontanelle), lambda (posterior fontanelle); sinciput (forehead); mentum (chin); vertex (highest point of the skull); and the occiput (area over the occipital bone). *tpm*

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Chapter summary

Key learning points

PARENT EDUCATION SERIES – PART 3: THE BIRTH AND BEYOND POSTNATAL PROVISION



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SUMMARY

The Birth & Beyond team is a dedicated group of Specialist Parent Education Midwives at The Royal Surrey Hospital who provide free and paid-for NHS parent education. The service was founded by Claire Barraud and Kate Conway as part of an incoming generating project. In part two we focused on the antenatal classes and courses offered. This article focuses on the postnatal preparation and classes offered by the Birth & Beyond team based on our five pillars of approach:

- Supporting parental and infant mental wellbeing
- Inclusivity
- Offering community
- Maintaining continuity of information and facilitation
- Ensuring a continuum of information throughout the pregnancy journey to early parenthood

INTRODUCTION

Our dedication to education, empowerment and supporting emotional wellbeing does not cease at the end of pregnancy. We acknowledge the fourth trimester to be a period of great transition, challenge and uncertainty. We work hard to foster ongoing peer support through the community and providing consistent information with ongoing midwife contact. Our Birth & Beyond services extend into the postnatal period for those wishing to access it. Our Complete course (a comprehensive paid-for package of antenatal and postnatal education) is inclusive of a four-week virtual Baby & Me course and an in-person baby massage course, with the same midwives and group cohort.

To increase accessibility and affordability, we offer stand-alone postnatal courses, baby massage and baby yoga. Our Birth & Beyond midwives have significant additional training in baby massage, baby yoga and wider training regarding topics such as colic, baby sleep and child development to enable appropriate knowledge levels and maintain expert-led services well into the postnatal period not traditionally covered by midwifery services.

"Doing Birth & Beyond was brilliant - I learned so much, felt supported and have made some friends for life." Complete client 2021

PARENTAL AND INFANT WELLBEING

What do you do to support postnatal mental health?

Post-birth the importance of good mental health for parents and babies cannot be underestimated. All of our antenatal classes (free and paid) feature mental health awareness, understanding and support, which is reaffirmed again in our postnatal services. We believe discussing such themes in pregnancy enables greater self-awareness and an ability to speak out when challenges are encountered after birth. We hope having open, frank conversations about the realities and challenges new parents may face will reduce any stigma or feelings of shame for those living with emotional disturbance or mental health illness.

The 6 C's is one of many tools designed by the Birth & Beyond team that we provide to safeguard and educate regarding mental health. The 6 C's are:

- Check In
- Connect
- Calm
- Care
- Contribute
- Collaborate

The 6 C's provide a framework for those wishing to enhance, where possible, their mental health and for those ready to actively participate in recovery. The 6 C's framework is provided to all those attending our antenatal classes and to those being supported by our perinatal mental health team - The Jasmine Team.

During our antenatal education sessions we encourage viewing the postpartum period as an opportunity for nurturing the new mother/birthing person and their body, baby and family unit as a whole. We discuss both physical and emotional recovery, facilitate opportunities to brainstorm regarding the partner role in supporting recovery and steps which can be taken in advance to prepare for the fourth trimester to enhance readiness and realistic expectations. We encourage our clients to write postnatal intentions in addition to birth intentions.

Our baby classes create an understanding environment for clients to venture out and socialise with their peers. The classes being midwife-led means we are on hand to reassure, answer questions and signpost to services for those in need. Having met many of our baby class clients in pregnancy facilitates enhanced trust, frank exchanges and an opportunity for us to maintain and continue valuable messages. These sessions offer more than just massage or yoga instruction. Having a skilled health professional available to observe, support and refer enables for a more effective service and safety netting for mental health illness.

"Being led by a midwife was hugely beneficial. It allowed me to dispel some of the overwhelming info on social media, particularly in relation to sleep expectations. Consequently, my baby has enjoyed contact naps galore and we both feel happier and more connected. Without her guidance, I would be drowning in the 'shoulds and shouldn'ts'." Complete client

"These sessions offer more than just massage or yoga instruction. Having a skilled health professional available to observe, support and refer enables for a more effective service and safety netting for mental health illness."

INCLUSIVITY

What are the advantages of involving partners in postnatal care?

Traditionally, parent education has been directed at the birthing parent. The perception that the education offered is not for them, along with working practices and timing of classes,[1,2] may prevent some partners from engaging with educational opportunities. Partners want to be involved in the childbearing continuum,[1] attending appointments and learning more about the antenatal, intrapartum and postnatal periods.[2] These barriers

may lead to feelings of apprehension and under preparedness.[2] This not only limits the co-parent's personal preparation for parenthood and the development of their own support network,[1,2] but may also reduce their ability to provide support for the birthing parent throughout the childbirth continuum.[1]

During a systematic review Ogbo, et al.[3] found partner support can influence a new mother's breastfeeding practices. Including partners in breastfeeding education improved breastfeeding initiation, duration and exclusivity rates,[3] impacting on the long-term health of the breastfeeding parent and baby. The collated data found support in the form of positive encouragement and emotional support, partner responsiveness and anticipation of the feeding parent's needs. A commitment to breastfeeding, assistance with managing breastfeeding challenges and help with household duties all improved breastfeeding duration and exclusivity.[3] Breastfeeding education should include information on how partners can support breastfeeding.

The exclusion of partners could have safety implications, such as the absence of safe sleep education as highlighted by the Lullaby Trust due to the exclusion of partners from appointments during the COVID-19 pandemic.[4]

The Birth & Beyond team actively encourage partners to attend all aspects of our parent education programme from relaxation and breastfeeding through to the baby care and postnatal classes. We also include images in our class promotion, which include partners. Many of our classes are provided outside of traditional working hours to facilitate the partner's access. Our educational content specifically includes exploration of the partner's role, mental health, changing relationships and their own relationship with the baby. We discuss practical ideas on ways partners can provide support and provide written information for them to reference later.

"Thanks for all you have done for us. We felt better prepared thanks to your support and training." Dad feedback following a Complete course

COMMUNITY

What is available in your area to foster connection and community?

Childbirth and parenting have historically been a village endeavour with our female relatives offering practical support and knowledge. Contemporary living and working practices mean many of us are isolated from family and our local communities. This modern disconnect has been raised as a potential contributing factor to postnatal depression rates. We believe it has never been more vital to encourage community within our pregnant and postnatal clientele. Having peers during maternity leave can create a sense of understanding and belonging by reducing feelings of isolation and recognising the shared challenges of parenting.

This was highlighted during the COVID-19 pandemic restrictions. Parents voiced the challenges of life with a new baby in a lock-down environment. Parents felt abandoned, isolated and lonely.[5] In response to this the Birth & Beyond team introduced Wellbeing Walks as soon as restrictions allowed. The walks enabled postnatal clients to meet with our midwives and local parents in parks for a walk and chat whilst maintaining the restrictions. Due to the popularity and the many benefits observed, our Wellbeing Walks continue with the added bonus of extending the invite to our antenatal clients, further widening our Birth & Beyond communities.

We create WhatsApp groups for each cohort. They provide a rich source of support and peer interaction. Many of our groups have formed lasting, meaningful relationships with their Complete course attendees, whilst also receiving robust, evidence-based antenatal education.

"We still use it now (WhatsApp group) to get us through the hurdles of parenthood! A great way to meet parents going through things just like you and so glad to have the extended support group to this day. We meet as often as we can and it's great to see the children grow! Would recommend it to everyone not only for the initial information (and welcomed reassurance!) but for the longer-term relationships too." Complete client

CONTINUITY

How do you support continuity of information?

There have been frequent calls to extend the midwifery model, recognising the value to mental health and confidence that the established midwife-mother relationship could bring to the vulnerable postnatal period.[2] One of the benefits of continuity of care, is continuity of information. In their 2019 study of continuity of information during the transfer of care from midwifery to health visiting services, Olander, et al. found one of the main concerns of clients was inconsistent information. Participants reported consistent and clear information positively influenced their confidence and trust in their healthcare providers.[6]

One of the successes of this continuity of information is our 5 R's. The 5 R's - Rest, Relax, Refuel and Rehydrate, Reposition and Reassurance - developed by Claire Barraud, are at the heart of everything we do and teach and are utilised by every midwife employed at Royal Surrey Hospital.

Providing a simple prompt to support physiology, particularly hormone regulation throughout the childbearing continuum, clients are taught about birthing hormones and how the simple activities of the 5 R's can enable them to support themselves, their partner and their baby throughout their pregnancy and postnatal journey. The 5 R's have been particularly successful because they are embedded in the maternity unit's culture. They are included in staff teaching, form part of our intrapartum care guideline and are even part of the delivery suite décor!

Consistent and clear information is an important consideration for the Birth & Beyond team. Consistent information provided by the team, clinicians and the maternity social media platforms enhances client confidence in the information shared and care received. This repetition supports client recall, enabling the information to be utilised for the empowerment of

their own experience. To that end our team train and work alongside a multidisciplinary team including the Maternity Voices Partnership, Patient Experience Midwife and the Clinical Professional Development team. Providing monthly education to staff during mandatory training also allows regular opportunities for staff to feedback their thoughts and experiences.

Birth & Beyond is led by a Senior Matron who has managed and developed it since its inception. This continuity not only supports the ongoing development of the Birth & Beyond brand but ensures robust governance of courses and content, professional revalidation and clinical supervision. While antenatal education as a whole remains unregulated, we can assure our clients that all aspects of Birth & Beyond are provided and covered by both the hospital governance framework and professional midwifery regulation within the NMC code.

CONTINUUM

What steps do you take to prepare families for the 4th trimester?

Whilst the original focus of antenatal education was to reduce or prevent pain associated with childbirth,[1] through birth preparation - an outcome for which there is little supporting evidence. More modern parent education programmes and policy documentation have widened the focus to preventing complications and supporting the wellbeing of the birthing parent and child.[1] Parental evaluations, particularly those completed in retrospect, highlight the wish for more information on the postnatal period - healing, changing roles and relationships - and practical baby care during antenatal classes.[1,2]

All Birth & Beyond programmes - paid and free - place as much emphasis on the fourth trimester as they do on preparing for birth. Our flagship Complete package, focuses more time (58%) on the post-birth period than on pregnancy, labour and birth. These postnatal elements are facilitated prospectively in pregnancy and contemporaneously during the fourth trimester with the same cohort of parents. Specific standalone courses remain available for all clients to attend in their postnatal period.

The antenatal elements encourage parents to prepare for the fourth trimester practically and emotionally. The postnatal elements reinforce and expand on information provided in the antenatal period but also introduce new information and skills, such as baby massage, play and sleep beyond the fourth trimester. Practical preparation includes stress management, post-birth planning and infant care activities, while emotional preparation invites clients to consider their postnatal wellbeing, lesser discussed emotions, bonding and attachment, changing roles and relationships, infant mental health and responsive parenting.

Education interventions which emphasise the natural capabilities of the unborn and newborn infant and the need for responsiveness found increased partner sensitivity during feeding interactions in the short term.[1]

CONCLUSION

Education regarding the postnatal period and the fourth trimester should be a vital component of any antenatal education programme to support realistic expectations and prepare both parents for the associated emotional, relationship and physical transitions. Ongoing support and education opportunities beyond the birth may enhance client satisfaction and mental health. **TPM**

"The (sessions) are packed full with so much information that has and will continue to help us over the coming days/ months / years. From the bottom of our hearts, thank you." Complete client



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Chapter summary

Key learning points

EDUCATION SERIES

9. OPERATIONALISING DOMAIN 4

ADDITIONAL CARE FOR WOMEN AND NEWBORN INFANTS WITH COMPLICATIONS

SUMMARY

In this ninth article of The Practising Midwife's education series, Domain 4 from the new Nursing and Midwifery Council (NMC) standards for proficiency is discussed. Domain 4 emphasises the midwife's role as a coordinator of women and neonate's care where additional care may be required. Highlighting curriculum changes at the University of Bedfordshire, Anna Madeley provides insights to how this domain has been implemented.



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INTRODUCTION

The NMC Standards for Proficiency for Midwives[1] informed by the Lancet series[2] has set in motion curricula development aiming to equip a generation of high-quality midwives with the skills and knowledge, facilitating support of women and families in their childbirth journey.[1,2,3] The most recent Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRACCE) Report[4] continues to emphasise the challenges we face as a profession in supporting the changing nature of women presenting for maternity care, the standards acknowledging this within Domain 4: additional care for women and newborn infants with complications.[1,p23]

Domain 4 underscores the approach to the midwife's role in not only providing safe and effective universal care, supporting and optimising normal physiological processes along the childbirth continuum, but also the requirement for the midwife to act as coordinator of care for women and their infants who fall into this category. It also reemphasises that midwives are ideally positioned to '*recognise any changes that may lead to complications*' and their *'specific responsibility for continuity and coordination of care… as part of the interdisciplinary team … acting as an advocate for women and newborn infants to ensure that they are always the focus of care*'.[1,p23] Additional care needs relate to antecedent, current and emerging medical, obstetric, social, physiological or psychological conditions

including any deterioration in a woman's condition or emergency, stressing the importance of respect for women's autonomy, choice and preferences.

SCAFFOLDING AND SPIRALS

Our pre-2020 curriculum reflected a linear, layered, scaffolded approach[5,6] according to a 'normal to abnormal to consolidation' structure, taught and assessed as discrete units, such as research in practice, anatomy and physiology (A&P) and medical conditions. Normal physiology with a strong lecturer-guided focus provided the foundations for scaffolding in year one, including A&P, childbirth physiology, research methodologies and public health. The second year developed the scaffolding, recognising deviations because of medical conditions, emergency care for women and neonates and medicines management.

Year three was designed to consolidate theory and practice by removing the scaffolding, facilitating transition to independent and critical thinkers,[5,6] concluding a project (literature review, research proposal or service improvement plan), preparation for professional practice (ethics, teaching and reflection) and midwifery practice within the multidisciplinary team. Practice-based units run throughout the three years.

Existing student, partner institution and service user feedback was sought to inform curriculum development and overwhelmingly there was a view that, although the existing 'normal to abnormal to consolidation' structure provided a firm grounding in safe and effective midwifery care, students were not being exposed in practice to just 'normality' in year one. Rather, students were experiencing complex, critical and emergency care from their first practice placements, regardless of the location. Acknowledging wider discussion around the term 'normal birth' within the midwifery and wider community, students were reflecting that a normality-focused first year left them unprepared for the reality of labour ward and the complex births they were witnessing while not yet having the underpinning knowledge to rationalise and understand what they were witnessing.

As NHS hospitals and practice partners continue to implement Better Births continuity teams,[7] students continue to be exposed early in their education to women who required a variety of additional care needs. It was obvious, therefore, that there needed to be a more innovative approach to how students are educated in relation to women and newborn infants with complications who require additional care.

We moved away, therefore, from focusing on the 'normal to abnormal to consolidation' structure to an integrated spiral curriculum approach. The spiral curriculum as a concept evolved from the work of Bruner[6] and scaffolding of knowledge, suggesting that students develop their knowledge founded on their own discrete experiences, past and present. Bruner suggested that where the basic concepts of a subject are taught early (including complexity), applying critical thinking and enquiry, then learners under the influence of educators' guidance, can start to instinctively apply what they have learned in a variety of contexts. A curriculum that introduces

PRACTICE CHALLENGE 1

How might you engage service users and practice partners in teaching in relation to Domain 4, such as multidisciplinary teaching within the university?

How might you respond to and integrate national and local drivers and emerging best available evidence into your teaching and assessment strategy over the next five years?

> *"Consolidate theory and practice by removing the scaffolding, facilitating transition to independent and critical thinkers"*

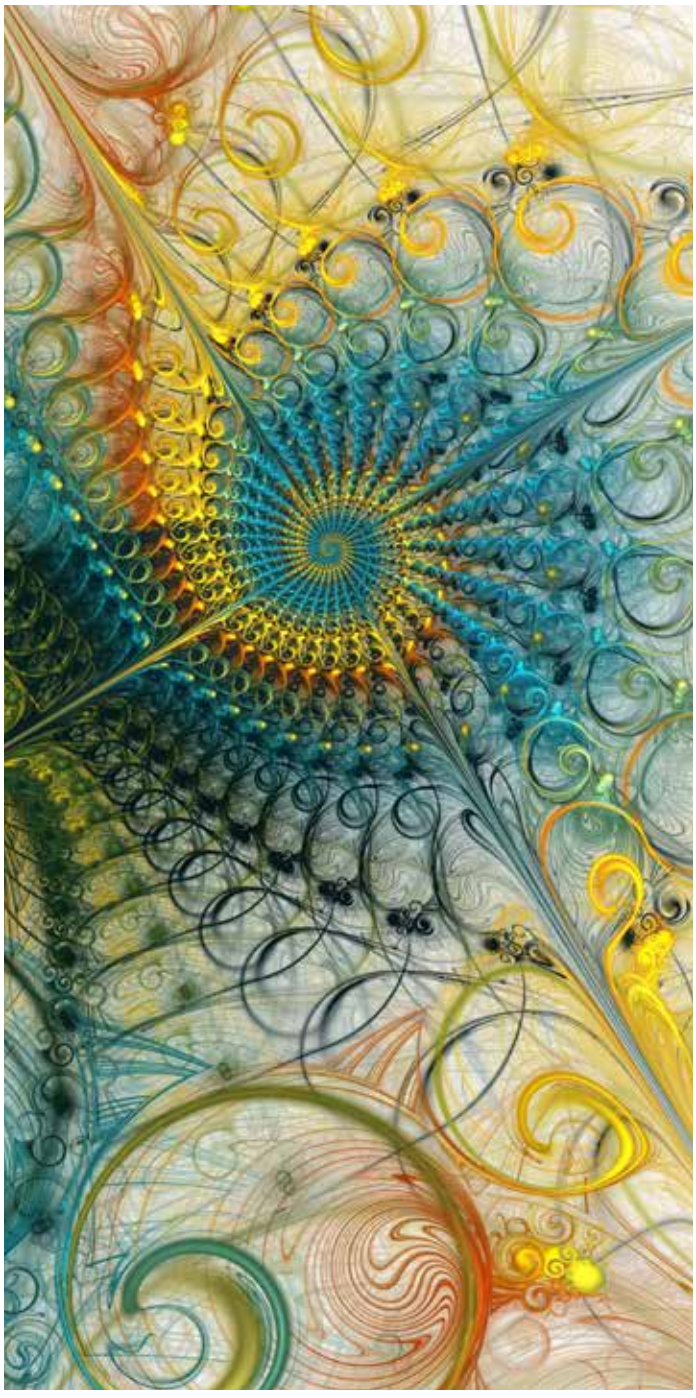


PRACTICE CHALLENGE 2

How as educators can we ensure that students receive equal and equitable experiences to support theoretical learning in relation to additional care needs?

What opportunities for reciprocal learning are available between the higher education institutions and practice partners to share good practice and experiences of students in practice?

What role might reflective groups play in this?



basic concepts throughout the first year and continues to revisit them throughout the program therefore not only negates issues around unpreparedness but has the potential to influence both critical thinking and dynamic practice very early in their education.

LAYING THE FOUNDATIONS

Domain 4 requires that midwives 'demonstrate knowledge and understanding that the complications and additional care needs... may relate to physical, psychological, social, cultural and spiritual factors' as well as requiring that registrants 'demonstrate knowledge and understanding of pre-existing, current and emerging complications and additional care needs that affect the woman, including their potential impact on the woman's health and wellbeing'.[1,p24-25] The academic team have worked hard to spiral common threads throughout the new curriculum including but not limited to reflection, research skills and critiquing techniques, socio-political awareness and contextualisation as well as medicines management – each of these featuring within the intended learning outcomes of every unit.

Students will be introduced in year one, alongside development of their knowledge of physiological processes related to childbirth, to a unit that aims to begin to explore pre-existing, current and emergent complications, cultural, socio-political and public health influences on childbearing as well as mode of birth, including operative and instrumental childbirth and their role as novice students in recognising when appropriate escalation and referral is required. This unit also provides context introducing the importance of national reports and drivers such as MBRACCE and the Kirkup Report.[4,8] It was important to the academic team to robustly position women at the centre of care and for students to learn from the women they work with. To this end, every assessment point involves an appreciation of women's narratives. Indeed, the first-year assessment explores the experiences of pregnant women living with chronic medical conditions alongside an examination of the physiology of that condition.

DEVELOPING KNOWLEDGE

Year two theory development goes on to expand knowledge, focusing on pathophysiology of childbearing as well as emergency care for women and newborns. These units run alongside and complement each other across two semesters, exploring traditional theory relating to pathophysiology of complexity and management of emergency conditions. The academic team felt strongly that learning is enhanced by facilitation of practice-related discussions, being able to apply theory in context but also searching for, critiquing and then applying best available evidence. Assessment for Pathophysiology in Childbearing therefore initially involves a computer-based examination to evaluate depth of knowledge across a broad range of conditions, but concludes with a literature review, investigating the pathophysiology of a medical or obstetric condition, presenting evidence supporting national and local guidelines with a focus on midwifery management, referral and care planning as well as accentuating the voice and experiences of the service user.

Domain 4 states that midwives *'use evidence-based, best practice approaches to respond promptly to signs of compromise in deterioration in the women, fetus and newborn infant and to make clinical decisions based on need and best practice evidence, and act on those decisions'* and *'to the management of emergency situations'* and *'demonstrate the ability to work in collaboration with the interdisciplinary and multiagency team'.* [1,p24-25.]

The unit The Midwife as Emergency Practitioner reflects the hands-on nature of responding to maternal and neonatal emergencies and is assessed via a multi-station objective structured clinical examination (OSCE) and Viva Voce consolidating knowledge of practical management. This prepares students to have courage in autonomously recognising emergencies, and manage and escalate complex situations to the multidisciplinary team appropriately. In order to support this, two years ago the university adopted the undergraduate PROMPT package[9] and uses this as part of the teaching strategy. This was overwhelmingly well received as it supports not only the standardisation of evidence-based approaches to management of emergencies but focuses on human behaviour and appropriate communication within the multidisciplinary team.

EMBRACING INNOVATION AND TECHNOLOGY

The use of technology has also focused on the development of the curriculum to support the proficiencies associated with domain 4, made explicit in domain 6[1,p37]: students having access to bespoke videos for obstetric and medical emergencies. The academic team have also developed an innovative use of lecture capture technology with quizzes embedded to support these skills and procedures (including aseptic nontouch technique (ANTT), venepuncture, post-surgical care, medicines management, amniotomy) as well as more abstract subjects such as including informed consent, difficult conversations and challenging poor practice. Research is ongoing to evaluate the effectiveness of these strategies in not only developing students' clinical practice, but also digital literacy, which is vital going forward in NHS hospitals adopting technology-based record keeping and prescribing.

One of the most exciting and challenging units in the new curriculum is situated at the end of year two. This will focus on care planning and considerations for women who choose care pathways outside of guidelines or who refuse care and treatment, exploring the midwives' responsibility to work in line with best available evidence while respecting and supporting that person's rights and excise of agency.[10] As an academic team we have heard students' frustration about how situations such as this are managed in practice. Therefore, we were keen to explore how women exising agency can be supported by effective care planning alongside the multidisciplinary team through individualised care planning. Assessment will focus on development of a care plan supported by national evidence and research.

The university is relatively unique in our approach to practice placement. Students have one face-to-face theory-based day



> *"There needed to be a more innovative approach to how students are educated in relation to women and newborn infants with complications who require additional care"*

at university, one personal study day and three 'in-practice' days per week, rather than the block model traditionally adopted by other universities. This has been retained in the new curriculum as it has, alongside the spiralled theory model, a number of benefits. Students are able to apply theory directly into practice, often in the same week, as well as having direct access to lecturers and peers on a weekly basis. Utilising timetabled reflection groups supported by both academics and the professional midwifery advocates (PMAs), both university and hospital based, experiences and challenges can be shared between students across our five practice sites. Teaching can be tailored in response to local and national events, thereby developing reflective literacy.

NON-MIDWIFERY PLACEMENTS

Current students undertake up to five months of 'non midwifery', non-assessed placements threaded throughout the second year to both contextualise and appreciate the work of the multidisciplinary teams and facilitate exposure to care pathways to which women with additional care needs may be following. These placements have been historically well received by students and practice partners alike because students are able to expand their knowledge outside midwifery-specific practice as well as complementing its quality. Experiences during these placements range from adult and neonatal palliative and emergency care to the provision of basic needs such as toileting, bathing and mouth care, discharge care planning and triaging. These are fundamental and valuable skills immediately transferrable to midwifery practice.

These placements have therefore been not only retained but expanded in scope and threaded across all three years. They have been aligned with theoretical input across all years and as such will complement classroom-based activities. Examples of these include medical ward or care home in year one, emergency department and neonatal unit in year two, and theatres and intensive care in year three. The scope of the non-midwifery placements has also expanded to wider interprofessional working, such as social work, which has reinforced the spiralled experiential learning and reflection. Interestingly, challenges around these placements come not from student midwives, but from feedback, most often from nursing colleagues mentoring students during placements who have expressed a lack of understanding as to why a student midwife is on what is traditionally seen as a 'nursing placement'. We clearly still have work to do to in developing knowledge around the role of the midwife in providing care to women and their families. Rather than seeing this as a barrier, we see this as an ideal opportunity to do so by allowing our students to reciprocally act as advocates for the profession.

CONCLUSION

It is vital that alongside the optimisation of normal physiological processes and recognition that midwives are, by virtue of their unique position as lead professionals for the care and support of women and newborn infants, optimally placed to anticipate, recognise and respond in an appropriate manner to additional care needs and complications.[1] Domain 4 makes clear the expectations of midwives at the point of registration and the care that they are able to provide in relation to additional care needs of the childbearing population. As that population and its profile changes, so must we as educators reflect these within curricula, providing robust theoretical and practice experiences. **TPM**

> *"Students have one face-to-face theory-based day at university, one personal study day and three 'in-practice' days per week"*

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Chapter summary

Key learning points

Hot Topic

HOW DOES WITNESSING A POSTPARTUM HAEMORRHAGE AFFECT PARTNERS' EMOTIONAL AND PSYCHOLOGICAL WELLBEING?

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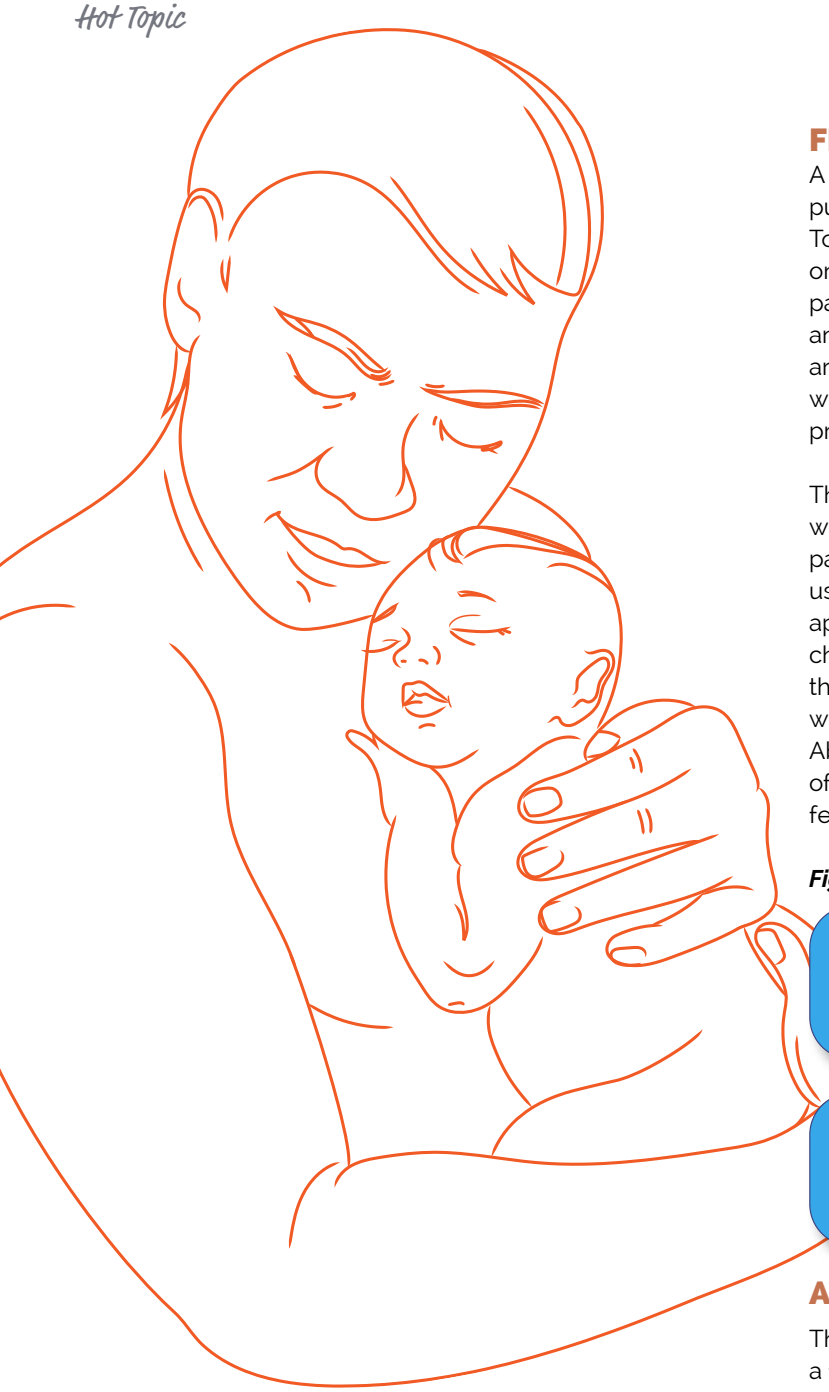


SUMMARY

Midwives, students, and birth workers often focus primarily on the health and wellbeing of the woman or birthing person (BP) and baby. It is easy to lose sight of their partner immediately postpartum, particularly in the event of an obstetric emergency. In this article, Hazel Chard evaluates the experiences and effects on partners witnessing a postpartum haemorrhage (PPH).

INTRODUCTION

Postpartum haemorrhage is the third leading cause of direct maternal death in the UK.[1] Global meta-analysis found that 10.4% of fathers experience perinatal depression.[2] Partners report feeling neglected and uninformed during traumatic births,[3] which can have an adverse effect on their mental health; this reveals that the phenomena of birth trauma is multi-faceted, impacting both the birthing person and their supporters present at birth. Whilst there is guidance available for midwives and birth workers on supporting maternal perinatal mental health, there is little guidance on how to support partners.[4,5] A literature search and evaluation was performed to identify existing research focusing on the fathers' and birth partners' experiences when present during a PPH.

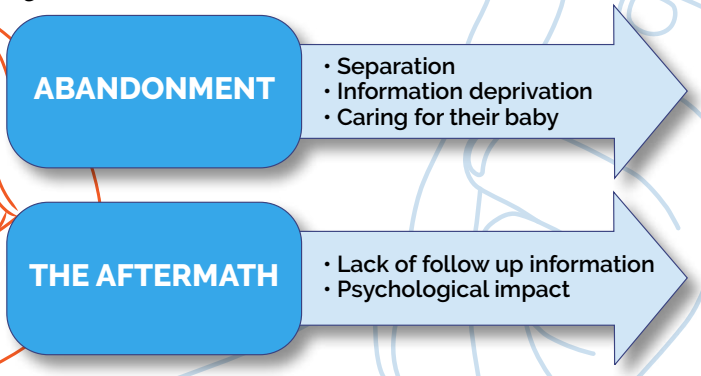


FINDING THE EVIDENCE

A literature search was conducted to find relevant papers published after 2010, to reflect a modern maternity system. To enable a detailed analysis of partners' experiences, only qualitative papers were included. Key words included: partner, experience, postpartum haemorrhage, mental health and their equivalents. Out of 241 academic papers, three articles met inclusion criteria: based in the UK for relevance, with direct data gathered from birth partners who were present at PPH.[6,7,8]

The three relevant papers had small participant groups and were focused on qualitative analysis of experiences for partners as well as birthing parents. Thematic analysis was used to identify areas of similarity between the studies; this approach ensures the recognition of patterns across the chosen literature regardless of the precedence of these themes in the individual studies.[9] The identified themes were similar across the three studies. Two broad themes of Abandonment and The Aftermath comprised of subthemes of communication difficulties, information deprivation, and feelings of exclusion (*See Figure 1*).

***Figure 1* (Themes)**



ABANDONMENT

The first theme identified by birth partners is of abandonment; a feeling of being torn apart, separated, ignored or left behind when an obstetric emergency occurs. As birth workers and healthcare professionals, it is easy to become swept up into caring for the woman/person at risk and losing track of the supporting person, who may be inadvertently pushed into a corner or asked to leave during the descent of supporting staff when the emergency bell is rung.

> *"Some people stated that they thought the lack of information meant their partner had died"*

Box 1: Practice challenge

Does your local obstetric emergency proforma include allocating a member of support staff to the birth partner and baby? Is there a safe, private and comfortable waiting area available for partners to use if the birthing person is taken to theatre?

Separation

Partners described being separated, without explanation and with few updates, as fearful and distressing.[6,7,8] There is no guidance stated within The Royal College of Obstetrics and Gynaecology (RCOG) Obstetric Haemorrhage Guidelines[10]

about partners needing to leave the birthing room. Partners emphasised their confusion over not being able to stand out of the way.[6]

Although being separated can be stressful for both the birthing person and the partner, it is also important to consider the healthcare professional's perspective. Though research on midwives' perceptions of partner presence was not found, a study by Duran et al.[11] found that healthcare professionals expressed concern over family members getting in the way or causing disruption during an emergency, diverting the attention away from the patient.

Information deprivation and lack of follow up information

Partners who were separated during the PPH felt excluded, abandoned, and wanted updates. Some people stated that they thought the lack of information meant their partner had died. Although the RCOG guidance[10] now states the importance of communication with the birthing person and partner throughout a postpartum haemorrhage, this was updated in 2016 and therefore was not available when the incidents in these studies occurred.

Strategies to keep partners informed were discussed, including the use of a family facilitator or an information leaflet. Limitations of these suggestions include leaving partners feeling overwhelmed with a leaflet without staff support, and the financial implications of a family facilitator.

Partners in all studies were disappointed by the lack of follow-up information. However, partners expressed their appreciation when professionals did take time to explain things postnatally.[6] All studies suggested that partners would have benefited from a postnatal debrief. Whilst the RCOG guidelines[10] suggest this is beneficial for the psychological wellbeing of the birthing person, the psychological wellbeing of partners has not been considered.

Caring for the baby

A theme throughout all studies was the expectation for partners to care for their baby during the emergency. Whilst one partner was given the option and declined due to not feeling mentally strong enough,[6] other participants described being left holding the baby and felt unsupported. One participant described his need to update family but felt unable to do so without provision for the baby. He felt as though it was easier to "stick him in a quiet corner".[11] In contrast, one participant described the joy felt whilst caring for his baby, however he felt his emotions were torn as the fear for his partner's life was also overwhelming.[7]

THE AFTERMATH

The second theme follows the long-term outcomes following obstetric emergencies including PPH. Although there is plentiful evidence following the women and birthing parents who experienced traumatic birth, the three studies identified a strong impact on the birth partners, whether they were fathers, friends or family members. Many postnatal services are intended to cater for people who are postpartum, not their supporters.

Box 2: Practice challenge

> Are there local services designed to support birth partners in your area? Is there a birth reflections or similar team that cater for partners and/or fathers as well as birthing parents?

Psychological impact

Some participants were able to witness the event, and whilst the desire for inclusion and information remained, the emotional impact was not detrimental in the long term. In contrast, other participants described the ongoing impact on their psychological wellbeing. Participants described various effects such as a nervous breakdown, post-traumatic stress disorder (PTSD), depression, flashbacks and a break down in marriage.[7,8]

One participant received counselling as a result of confiding in their GP.[8] However, another was told "your wife was the one who experienced the trauma… you need to pull yourself together and support her".[7] This had a detrimental effect on his mental health. It has been evident in recent studies that partners struggle to admit their feelings, describing the need to 'man up' and be strong, as well as breaking down in private so their partner would not see.[12,13] Men are three times more likely to commit suicide in the UK than women[14] and the majority of birth partners are male; it is therefore imperative that perinatal mental-health guidelines are extended to include the wellbeing of partners.

> *"It is therefore imperative that perinatal mental-health guidelines are extended to include the wellbeing of partners"*

CONCLUSION

The care provided by healthcare professionals plays a vital role in how partners later perceive the event. When partners felt abandoned and deprived of information they later perceived the event as traumatic, especially when they believed their partner had died. Acts of compassion made a lasting impression on partners' perceptions of the event. Partners trusted the judgement of healthcare professionals and had little expectation in decision making. However, they wanted to be involved and updated. Postnatal debriefing was recommended by all studies. When partners perceived the event as traumatic, this led to a breakdown in relationships, flashbacks, postnatal depression and PTSD. **TSM**

Box 3: Recommendations

- Further qualitative research focused on birth partners.
- Clear protocols for the presence and support of partners during emergencies.
- Debriefing or supported reflections offered to all experiencing an emergency, from families to staff.
- Provide staff training and resources on mental-health provision for birth partners.



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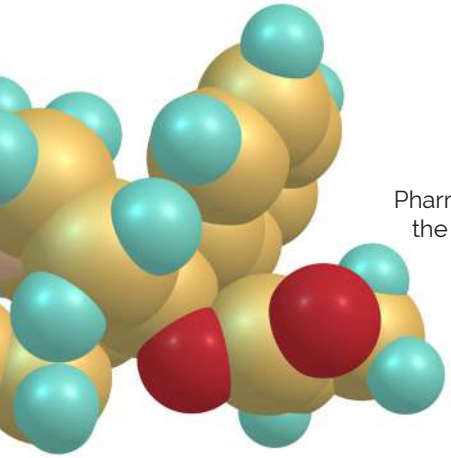
Chapter summary

Key learning points

The dilemma of medication and breastfeeding FOR STUDENT MIDWIVES



During my PHD research I learned that the number of mothers told they cannot take medication whilst breastfeeding is large. This is also represented by the number of contacts to the *'Breastfeeding Network Drugs in Breastmilk Service'* and my own website; *'Breastfeeding and Medication'*. Sadly, deciding to breastfeed discourages some mothers from taking medication, believing this will preserve the purity of breastmilk. However, much of this is based on mistaken assumption and flawed understanding. In addition, this situation is further exacerbated by confusing direction from healthcare professionals. In this article I provide simple messages to help midwives and students develop a reliable knowledge base to educate women.



AUTHOR

Dr Wendy Jones MBE
Pharmacist with special interest in the safety of drugs in breastmilk

INTRODUCTION

Schirm (2004) showed that 65.9% of women have taken a pharmaceutical drug whilst breastfeeding their baby in the first 6 months after birth, whilst 79.6% of formula feeding mothers have taken a drug during the same time period. In my PhD research I found that 56.5% of breastfeeding mothers received some medications in the first 5 days after delivery, mostly analgesics and antibiotics, as might be expected. However, in my experience mothers will also "put up" with pain and other discomfort rather than interrupt breastfeeding. In addition, an unknown number of women never seek help for mental health problems fearing that they will either be told that they must stop breastfeeding or be considered unfit mothers causing their babies to be removed from their care.

SO HOW CAN THE MIDWIFE HELP?

Many women come to the end of their pregnancy without knowing whether they can breastfeed on the drugs they have taken during pregnancy or drugs that they may need to restart following birth. So, my first request is that you find time during the booking appointments to check whether the expectant mother is in this position. Can you imagine how tough it would be to have birthed your baby and suddenly to be told you can't breastfeed because no one knows if your medication is safe? What if it is midnight and there is no one on call to ask? Those first precious hours of skin to skin and early feeds might be lost. The new mother may be discharged before the issue is resolved, therefore losing the valuable expertise of the healthcare professional on breastfeeding positioning and attachment.

This is my first take-home message:

If a mother needs medication long-term, check the evidence on use during pregnancy AND during breastfeeding. Do not rely on the BNF check with specialist sources (NICE, PH11).

PHARMACOKINETICS

I remember having a panic when I was first asked to talk about the pharmacokinetics of drugs in breastmilk, but I'm going to try and make it as easy as possible to understand, with lots of diagrams and one-word descriptions.
First, what does pharmacokinetics mean? It is the branch of pharmacology concerned with the movement of drugs within the body: how the body absorbs drugs, moves them into the blood and then into milk. Do not forget that once the baby has consumed the milk, he/she also has to absorb it, metabolise it and transport it before it is going to have an effect. There are a lot of processes between the mother being given a medication and the baby responding to it.

HALF-LIFE

The half-life of a drug is the time it takes to be metabolised to half the original level. So, if at one minute there was 100mcg and the half-life is two minutes – after two minutes there is 50mcg left, after four minutes 25mcg and so on. After five half-lives the amount left is regarded as so small that it can effectively be said to have left the body, see *Figure 1.*

The problem comes when a drug is taken every day, but the half-life is more than 24 hours, particularly if the baby is under 6 weeks and has immature kidney and liver function. Worse still, there are at least two commonly used drugs, fluconazole (used to treat vaginal candidiasis and fungal infections of breast and mouth) and pethidine, where the half-life in a neonate is considerably longer than that in an adult.

Fluconazole: half-life in an adult is 30 hours. But in the baby, it is 88.6 hours at birth, 55.2 hours at 2 weeks of age (Pacifici 2016).

Pethidine: half-life in an adult 2.4 hours (normeperidine active metabolite 15-30 hours). But in the baby, it is 13 hours (normeperidine active metabolite 63 hours) (Hale 2019).

These drugs therefore begin to accumulate because so much of the drug is left every day when the mother takes more. This can lead to toxicity. Babies exposed to pethidine in the neonatal period may become sleepy and feed poorly. In my experience babies under 6 weeks exposed to fluconazole via breastmilk often display symptoms of tummy pain, vomiting and often weight loss.



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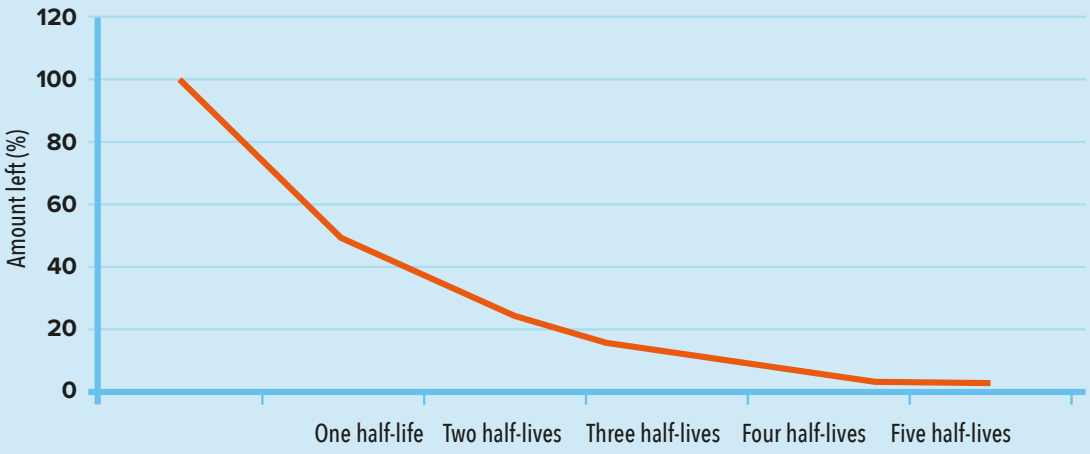
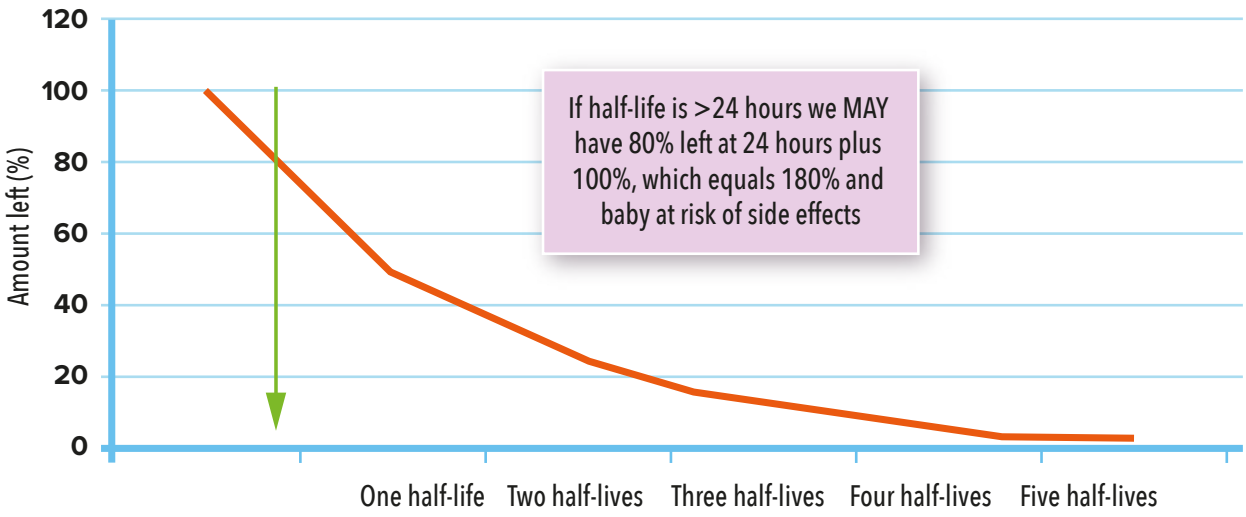


***Figure 1* Half-life of drugs.** Reproduced from Breastfeeding and Medication, copyright Dr W Jones (2019).

***Figure 2* Half life of drug over 24 hours.** Reproduced from Breastfeeding and Medication, copyright Dr W Jones (2019).



ORAL BIO-AVAILABILITY

The oral bio-availability of a drug is the percentage of the drug absorbed into the system having passed through the gut, liver, vagina, rectum or lungs. Most drugs given by injection only (i.e. there is no oral formulation available) have poor bio-availability e.g. insulin, heparin. If a drug cannot be absorbed from the gut, it doesn't matter how much gets into milk, the baby can't absorb it e.g. gentamycin, infliximab.

THE EXTENT OF PLASMA PROTEIN BINDING OF THE DRUG

When drugs enter the maternal bloodstream (after absorption), they either become bound to plasma proteins or remain free. Only the free part of the drug can penetrate the biological membranes. The more drug that is bound, the less it is free to diffuse. Highly protein-bound drugs are unable to penetrate breastmilk, for example, most penicillins. Drugs with high protein binding are the drugs of choice for administration to lactating mothers. Some drugs compete for binding sites normally occupied by bilirubin in the first week after birth. Drug displacement of unconjugated bilirubin may result in kernicterus and brain damage in the infant and a theoretical risk exists with some drugs e.g. co-trimoxazole.

An analogy that I often use is that the drug is attached to a Lego® brick so it becomes too big to pass through the cell membranes.

MILK–PLASMA RATIO

This measurement refers to the concentration of the protein-free fractions in milk and plasma. Any ratio over 1 implies that the drug may be unsuitable to be prescribed for a lactating mother (because it concentrates in milk) and other factors need to be taken into consideration.
For example, fluoxetine has a milk–plasma (m/p) ratio of 0.286, while the m/p ratio of dexamphetamine is quoted as 2.8–7.5, which means that the level in the milk is approximately 3 to 7.5 times that in the plasma. Milk plasma ratios of 26 have been reported in iodine which is why it should be avoided (this includes the use of seaweed and kelp in herbal remedies and application of Inadine® dressings)

THE SIZE OF THE DRUG MOLECULE

The larger the molecule, the harder it is for it to pass into breastmilk. For example, low molecular weight heparins (molecular weight 6,000–20,000) and insulin (molecular weight >6,000) are restricted from passing into breast milk. These drugs are usually not orally bio available.

THERAPEUTIC RANGE

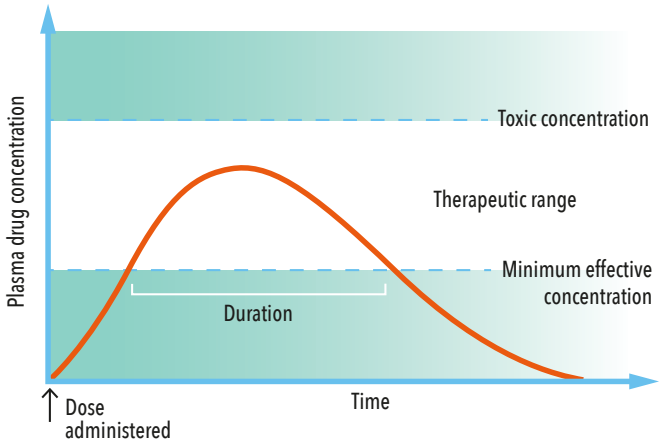


***Figure 3* Therapeutic range of drug, reproduced from Breastfeeding and Medication, copyright Dr W Jones (2019).**

Drugs which are licensed for use in children will almost invariably be safe for use during breastfeeding as they will reach levels below the minimum effective concentration. We aim to target the mother's dose into the therapeutic range. Sometimes mother and child will be taking the same drug simultaneously e.g. both on paracetamol or antibiotic.

The amount passing through milk does not affect the dose that the baby is taking because these drugs have wide therapeutic indices. Both mother and baby can take their full normal doses.

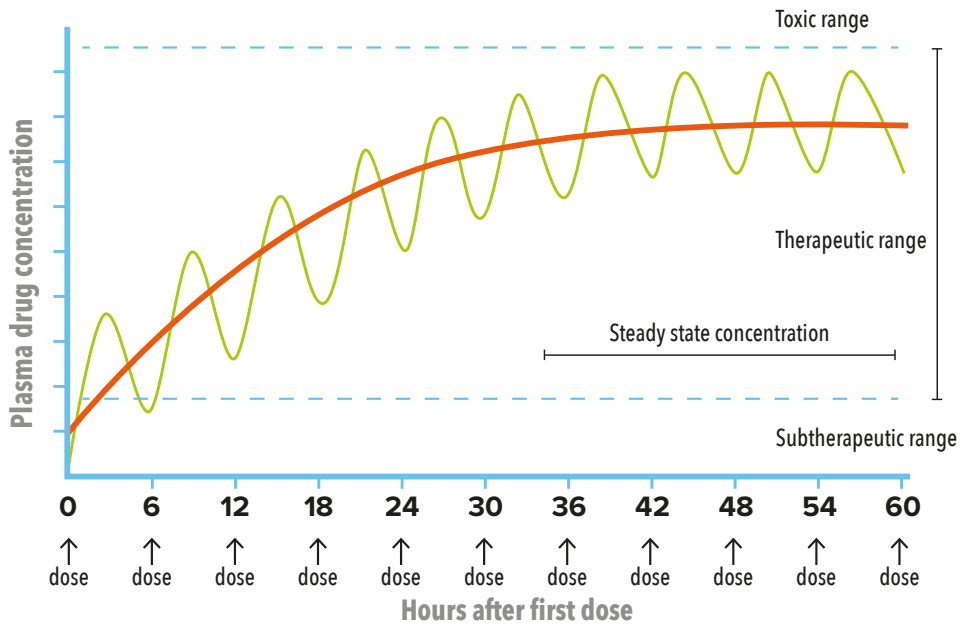
So, the second take home message is:

- Try to avoid drugs with long half-lives particularly in neonates
- Use drugs with high plasma protein binding > 90% if possible
- Choose drugs with milk plasma ratio less than 1
- Drugs with high molecular weights are limited in their passage into milk
- Drug licensed for use in children are ideal and will reach levels below effective

TIMING MEDICATION AND BREASTFEEDS

Many mothers try to time breastfeeds to avoid the peak times that the drug is in milk. This only works for very acute exposure to drugs. When any drug is used for more than 3 days it reaches a steady state where the level is constant across the 24 hours. So, it isn't possible to reduce exposure with long-term medication e.g. antidepressants.

***Figure 4* Diagram from How Drugs Work:** Basic Pharmacology for Healthcare Professionals, McGavock (2005)



> "An analogy that I often use is that the drug is attached to a Lego® brick so it becomes too big to pass through the cell membranes"

PASSAGE OF DRUGS INTO BREASTMILK IMMEDIATELY AFTER DELIVERY

The only time when a drug is free to pass into breastmilk is in the first few days after birth when the inter-cellular gaps are wide open to allow the passage of immunoglobulins to the baby for protection. This is, however, the time when we are most likely to prescribe drugs for the mother e.g. antibiotics, analgesics. However, obstetricians and paediatricians are more familiar with prescribing during breastfeeding and are, in general, more confident than their fellow medical colleagues who may see breastfeeding mothers later down the line.

The intercellular gaps close around day 3 after birth and drugs then must pass through the cell membrane which is much more difficult.

CONCLUSION

I hope this article has made this topic clearer, it is a tricky subject and one which I believe makes many health professionals panic. The take home message is that the vast majority of drugs can be taken by breastfeeding mothers and if not, there is usually an alternative. No breastfeeding mother needs to be left in pain because codeine is not recommended – she can have dihydrocodeine as well as paracetamol or Non-Steroidal Anti-Inflammatory Drugs instead. No mother needs to stop breastfeeding to have an antibiotic or an anaesthetic. No mother should be asked to choose between having medication for mental health issues and breastfeeding.

I am always happy to help provide information – email me on **wendy@breastfeeding-and-medication.co.uk** or via the Facebook Page **'Breastfeeding and Medication'** or 'The Breastfeeding Network Drugs in Breastmilk information service Facebook page'.

There are many factsheets on the *Breastfeeding Network* website or the *Breastfeeding and Medication* website

Please share them with colleagues and good luck in your careers.

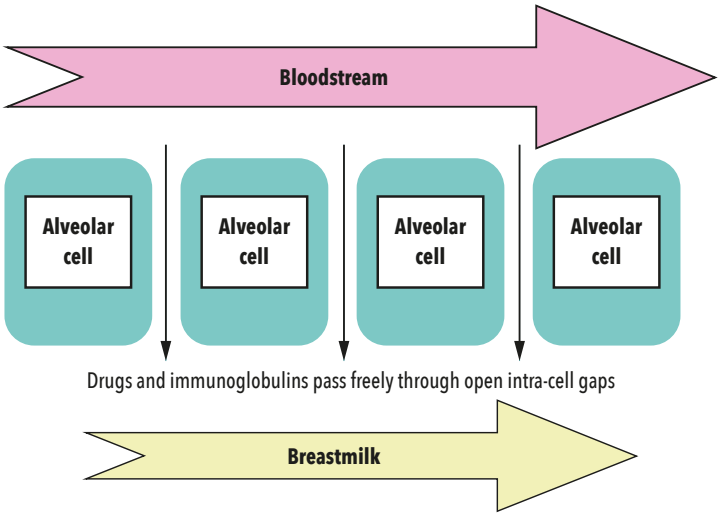


***Figure 5* Drugs and immunoglobulin passage to breastmilk.** Reproduced from Breastfeeding and Medication, copyright Dr W Jones (2019).

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Chapter summary

Key learning points

CULTURAL SAFETY IN MIDWIFERY PRACTICE – PROTECTING THE CULTURAL IDENTITY OF THE WOMAN

SUMMARY

This paper discusses the importance of cultural safety in midwifery practice. Recently the NMC (Nursing and Midwifery Council)[1] produced standards on proficiencies for midwives stating the importance of combining clinical knowledge with cultural competence during midwifery practice. However, it is suggested that midwives should be engaged in working towards 'cultural safety' and be prepared to challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of the women they care for.[2,3,4] We must acknowledge the impact of midwives' professional and workplace culture on providing culturally safe care during pregnancy. In particular, the importance of midwives acquiring cultural safety during practice is key and the strategies that can be used to achieve this.



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THE CONCEPT OF CULTURAL SAFETY

The concept of cultural safety has been around since the 1980s and was developed in New Zealand to cater for the needs of the indigenous Maori population.[5] Williams states the concept of cultural safety as an *'environment that is spiritually, socially and emotionally safe, as well as physically safe for people; there is no assault, challenge or denial of their identity, of who they are and what they need'*.[6,(p213)] In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the woman.[3] Women should be valued as cultural beings who have a personal view of how they wished to be cared for during pregnancy. Cultural safety stipulates that midwives should not focus on learning cultural customs of different ethnic groups but focus on being aware of differences, consider power relationships, implement reflective practice, and allow the woman to determine whether a clinical encounter is safe.[7,8,3] Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual or does not recognise the cultural identities of individuals.[9,10] Cultural safety is needed in midwifery practice and should be a basic human right for all pregnant women.



MIDWIVES' PROFESSIONAL CULTURE

The midwifery profession has developed a culture with norms and beliefs guided by the statutory framework of the NMC that may impact on the achievement of cultural safety. Midwifery culture may also be internalised by individuals entering the profession created by training and teaching methods, which individuals adopt in order to become part of the profession.[11] The professional code of conduct specifies how a midwife should behave in order to maintain the integrity of the profession.[12] The midwifery professional culture may be conformed to despite the individual midwife's own cultural beliefs. It is alleged that healthcare professionals tend to lean towards ethnocentrism, whereby a person judges the culture of other people from the point of view of their own culture.[13,14] Any ethnocentrism in midwifery practice may result in a disregard of other cultures and lead to dominance of one's cultural beliefs over others, which conflicts with the concept of cultural safety. Unfortunately, midwives have been socialised into assuming control as part of their autonomous role, resulting in failure to identify and legitimise the cultural identity of the women they care for.[2]

WORKPLACE CULTURE

The workplace environment also has influence on the individual midwife's behaviour and views. A workplace environment can influence how things are done, who does what, and defines the hierarchical structure of an organisation.[15] Workplace culture is comprised of behavioural norms and practices that are expected and 'allowed' within a workplace.[16] If there are particular ways of performing or behaving in a workplace, this may become an integral part of a midwife's beliefs and attitudes. There may also be conflict between the midwife's beliefs and workplace practices that impacts on the quality of care that is provided to women. Some maternity units may have adapted practices that embrace women's cultural needs or this could be the opposite. The woman's cultural needs may fall to the bottom of the agenda when there is overwhelming pressure on maternity services such as during the COVID-19 pandemic. Cultural safety acts as a buffer against factors that impact on service provision which in turn may affect the quality of care.

> *"Any ethnocentrism in midwifery practice may result in a disregard of other cultures and lead to dominance of one's cultural beliefs over others"*

INTEGRATING CULTURAL SAFETY INTO MIDWIFERY PRACTICE

Using critical consciousness

It is essential for midwives to recognise the assumptions and beliefs behind their thoughts and actions; they should recognise that the way they practice midwifery is influenced by their beliefs.[17] There is a call for midwives to understand the bicultural nature of the patient-practitioner relationship, beginning with themselves, their own race, culture and imprinted stereotypes.[18] Midwives need to be engaged in working towards cultural safety during midwifery practice by using critical consciousness. To do this, midwives must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and the cultural systems in which they provide midwifery care.[3] This challenge of the midwife's own culture should be a subconsciousness process on a daily basis when caring for any woman, something that is always 'at the back' of the midwife's mind.

Involving women in decision making

Midwives should regard cultural competence as representation of good clinical practice and should regard each woman in the context of her own culture, as well as from the perspective of their own cultural values and prejudices.[19] Taking this approach inadvertently sets a basis for a culturally safe interaction where the woman is able to verbalise her views and foster a trusting relationship. Culturally safe midwifery practice can be achieved when there is no unintentional disempowering of women: indeed, where women are involved in the decision making and become part of a team effort to maximise the effectiveness of their care.[8] This should be a requisite for all midwife-client interactions; asking the woman to discuss her care needs at every stage during pregnancy opens up the opportunity for such interactions to occur.



CONCLUSION

Midwives need to be made aware and educated on the tools that can be used to develop cultural safety. Developing critical subconsciousness of cultural views is required by a midwife when caring for women and understanding that involving women in decisions made about their care is crucial for cultural safety. In particular, acknowledging that it is the woman who states that she has received culturally safe care is relevant. Organisations should be aware of any workplace cultures that can impact on the midwife placing the woman's culture at the centre of her care and allowing her to be involved in decisions about her care. Adopting these approaches can achieve cultural safety and effective midwifery practice that places the woman in a culturally safe environment and protects her cultural identity. **TPM**

ACKNOWLEDGEMENT

Thank you to the Iolanthe Midwifery Trust who have supported my studies in this area.

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Chapter summary

Key learning points

PROFESSIONAL MIDWIFERY ADVOCACY IN HIGHER EDUCATION:

AN EVALUATION OF AN INNOVATIVE IMPLEMENTATION OF THE A-EQUIP MODEL

SUMMARY

Educational PMAs are developing ways of working with the A-EQUIP model. PMAs at Birmingham City University have developed restorative clinical supervision (RCS) sessions using appreciative inquiry with midwifery students. Evaluation was overwhelmingly positive and RCS has been rolled out across all years of the programme. There is a distinct role for educational PMAs.



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A-EQUIP

The A-EQUIP model of clinical supervision was launched in midwifery following the removal of statutory midwifery supervision in 2017.[1] A-EQUIP is an acronym for advocating for education and quality improvement and was inspired by Proctor's model of clinical supervision[2] and Hawkins and Shohet's[3] adaptation of this model. Of particular note is the restorative function of the model, which has been shown to: have a positive impact on the immediate wellbeing of staff; help staff to feel 'valued' by their employers for investing in them and their wellbeing; influence a significant reduction in stress; influence a significant reduction in levels of burnout; improve the compassion and job satisfaction of staff and improve the retention of staff.[4]

A-EQUIP IN MIDWIFERY EDUCATION

Unlike for clinical practice, a distinct role for the professional midwifery advocate (PMA) in universities in relation to undergraduate midwifery provision has not been formerly described in the literature or by NHSE.

At Birmingham City University (BCU) the lead PMA has practical links to practice with a local hospital's PMA team, but wanted to extend the A-EQUIP model to the university setting, too. The concept of A-EQUIP had already been taught across the curriculum, and will be continued within the Future Midwife[5] curriculum. This is in common with other education providers.[6,7] Students are also introduced to and supported by our partner hospital's PMA teams in the clinical areas from year one of their course.

However, the PMA lead at BCU decided to introduce restorative clinical supervision to student midwives in a university setting. In conjunction with another PMA at the university, this was put into place for the 2018/2019 academic year with the first-year student midwives. Every first-year student midwife was enabled to experience a group RCS session that was facilitated by a university PMA. The RCS session was timed to occur half way through the academic year and followed the student's first assessed clinical placement and academic assessments, but was prior to subsequent assessments in academia and placement. It was felt it was an apt time for students to reflect on their feelings, thoughts and inspirations from these experiences and to look forward to and prepare for their next experiences.

Students were randomly allocated to groups of no more than eight students. The sessions occurred over a two-week period and were an hour long each. Prior to the sessions, students were given information about RCS, the basic process and the outlines of a contract that was firmed up and agreed at the start of the RCS session. Group supervision is a recognised approach and has been shown to be effective for midwives.[8] However, Ghaye and Lilyman[9] caution that group reflective sessions can be problematic and hazardous if not facilitated well. Consideration of group dynamics occurred and control and facilitation went smoothly.

The RCS session was conducted using the underpinning theory of appreciative inquiry. Following a checking in activity, the students were asked:

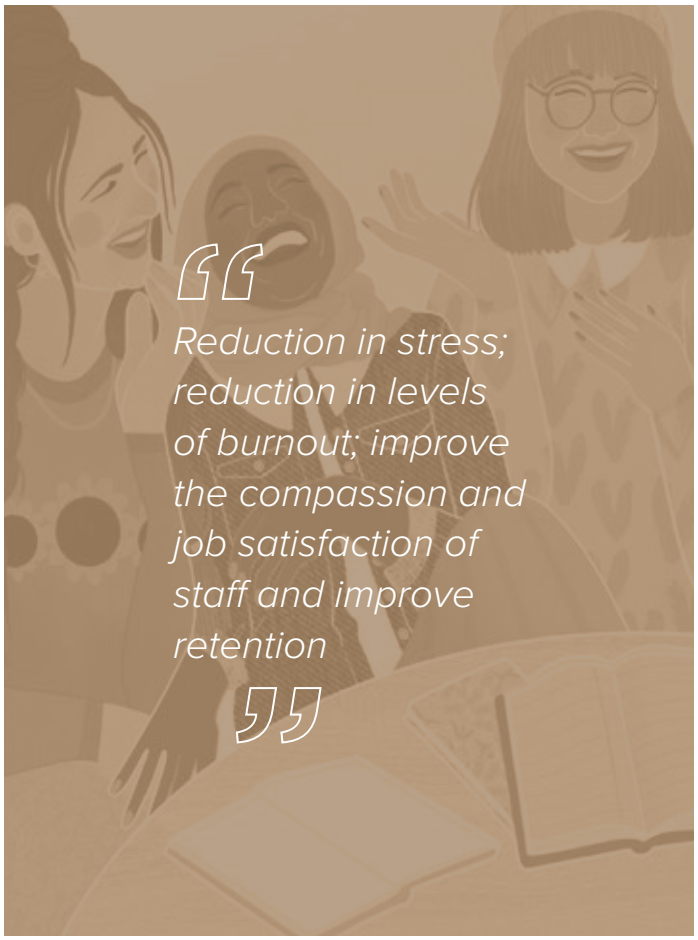
"So, you have all experienced your first introduction to placements and to assessments. Thinking about your role and abilities, what is going to be your greatest strength? Have any of your recent actions demonstrated this strength?"

The idea was to use appreciative inquiry as a medium to encourage motivation and progress, ultimately leading to change. Appreciative inquiry is underpinned by five generic processes[10] (Mohr and Watkins 2002) detailed below with examples of potential responses:

1. Choose the positive focus of the inquiry (opening question as above).
2. Inquire into exceptionally positive moments (as arise in the session, what roles they enjoyed, what they believe they do well...).
3. Share the stories and identify the lifegiving forces (e.g. what is it about x's experience that made it so positive, what did she do, tips, structure, what factors exist at your hospital to facilitate these good feelings...).
4. Create shared images of a preferred future (e.g. what would you like your next placement to be like, future placements and future clinical learning experiences to be like).
5. Improvise ways to create that future (e.g. acknowledge some experiences were not so positive – how can you, as a group, cohort, team and buddy improve your experiences and create more positives? What changes might you like to see in your own practice or hospital?).

The session ended with a final positive comment or thought before everyone checked out.

The overall goal was for the students to learn from positive moments rather than focusing on any breakdowns that had occurred. It is a process that has been utilised by PMAs with midwives successfully before (personal reflection). By using Appreciative Inquiry, there is a belief that every organisation has a positive core and this is inclusive of strengths, peak experiences, best practice and successes and key learnings. When the PMA focuses on the positive core, the PMA brings it to light.[11]





> *"The restorative function of the model has been shown to: have a positive impact on the immediate wellbeing of staff; help staff to feel 'valued'"*

FINDINGS

Students undertook the RCS sessions with one of the two PMAs at the university, with 39 students returning a simple evaluation form that was given two months after the RCS session was conducted. Most students answered all questions and a few did not, which accounts for differences in statistics (*Table 1*).

***Table 1* Student's evaluation of the RCS sessions**

Have you attended any single one-to-one RCS sessions with the PMA?	Yes	No
	6	33
Would you like another RCS session?	35	2
Did you enjoy the RCS session?	39	0
Did your mood improve following the RCS session?	35 Some students provided a narrative response: 'all in the same boat'; 'opportunity to share concerns'; 'more confident for the next placement'; 'happier'; 'yes, but not massively; and 'yes, felt more positive'	2
Had your knowledge on RCS improved following the RCS session?	37	0
Had your knowledge on the role of the PMA improved following the start of your midwifery course?	38	1 This student rated their knowledge as worse!

Students were asked for a free narrative response about their perceived benefits of the RCS session that they had experienced. The key points that were evident from responses are discussed here and expressed in the Wordle below.



Of particular note were the opportunities to share experiences and feelings and not feel alone in their thoughts and feelings. Students said it was *'good to know that others had similar feelings to me'* and *'[I] realised people felt the same as me'* and *'[I] didn't feel alone'.* The students treasured the time to listen and be heard: *'I knew there were people I could speak to'; 'express feelings'; 'share experiences'*; and *'I could discuss worries and concerns'.*

The ability to have a safe voice, speak and share with others was also valued. Peer discussions and advice were appreciated, it was a *'chance to talk through issues with peers'; 'share ideas with peers'; 'learn from others';* and *'hear other people's experiences'.* It helped with the cohort's sense of belonging and connectedness – students commented that it aided *'bonding with other cohort members';* that they *'talked to other people I wouldn't normally talk to';* and that it helped with *'relieving stress hearing other people's thoughts'* or they were able to *'voice thoughts in a safe environment'.*

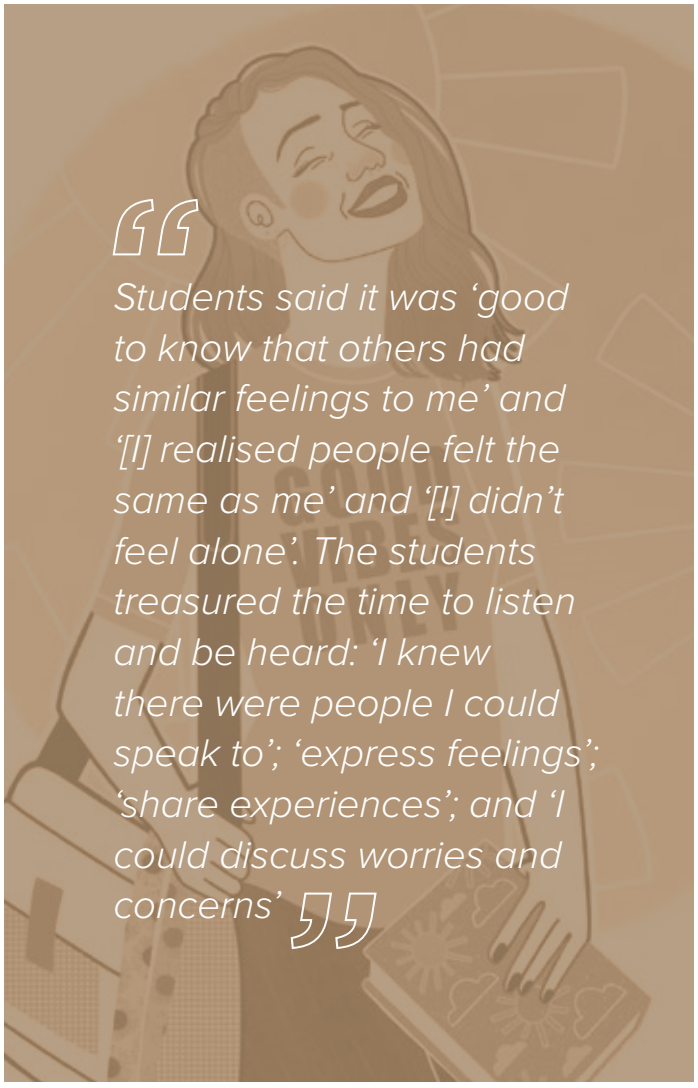
Some of the narratives demonstrated gains in confidence and an appreciation of sharing of concerns, which led to a happier state of mind and ability to reflect. Comments were around *'reflecting on experiences on placement'*; *'group discussion with new people'; 'reflection'; 'having someone to listen to me'; 'positive attitude throughout'; 'more confident for the future'; 'talk openly'; 'knew there were people I could speak to'*; and the sessions *'supporting development'.*

When asked what the students would like to have been done differently, more than 40% wanted more frequent RCS sessions, and some wanted to extend the length of the sessions. Although some sessions were slow to get going, which we put down to the newness of the situation, once talking, students were enthusiastic and opened up, discussing issues that were important to them in the confidential and safe space. Interestingly, some wanted the sessions to occur earlier in the academic year and one person even wanted 'tea', which plays to the relaxed, comfortable nature of the sessions. Nobody wanted to abandon the sessions.

DISCUSSION

Student midwives at BCU clearly enjoyed their group RCS sessions. As a result, these sessions were timetabled again for a new cohort of first years and were added in for the second- and third-year students. More PMAs have now joined our team to enhance our provision of support. This directly met the needs that students expressed: they wanted more RCS and we provided it. Although single one-to-one sessions were also available to students, these were not utilised frequently. We need to promote these opportunities more widely. It appears that experiencing RCS first hand is an effective way to teach about RCS in addition to providing the benefits of RCS itself. Experiential learning, the process of learning through doing, is a known theory of learning[12] and a core strategy in midwifery education. The benefits of RCS are known[4] and, as described in the Wordle, the students had overwhelming positive impressions, with 90% of students feeling their mood had improved following the RCS session, and importantly no one declared that they felt worse.

In line with midwifery colleagues' sentiments[7] and the wider national reports of students' mental health and wellbeing, strategies to promote and enhance students' wellbeing are welcomed.[13,14] Many factors have been suggested as contributing to the rise in cases of mental ill health among students: work pressures, moving away from home, financial worries and higher education institutions are feeling the impact of the rise in metal health conditions among the 16-25 age population.[14] However, concern has been expressed about the availability of support for students with mental health conditions and the response of universities.[14] The use of the PMA providing RCS is one attempt in a package of the university's health and welfare support systems, all aimed at promoting all students' wellbeing, with or without declared mental health issues. It is particularly important as student midwives fall into an at-risk group of students because most of them are women, they are undergraduates and they are full-time students.[15] In addition, just under half of students who report experiencing a mental health condition choose not to disclose it to their university.[14] In addition, people aged 20-24 are less likely than any other age group to record high levels of wellbeing (life satisfaction, feeling that things done in life are worthwhile, happiness and low anxiety).[14] Increasingly, the midwifery students have predominantly fallen into this age group following the changes to bursaries.



CONCLUSION

There is a clear role for the educational PMA. Students appreciate and gain from the same benefits available to clinical midwives. Positive educational experiences may help students engage in RCS upon qualification. Educational PMA services will continue to be developed to meet the needs of the students and PMAs will continue to signpost to dedicated, specialist services if necessary. **TPM**

FUTURE RECOMMENDATIONS

All midwifery education staff should be trained in RCS so that facilitation of RCS can be expanded even further.

Expansion of group RCS to all midwifery cohorts to provide the benefits to all students.

Further development and advertising of one-to-one sessions to improve awareness and uptake.

Continued development of strong links between hospital and educational PMA provision.

Development and embedding of the PMA role in the Future Midwife curriculum.

Create a toolkit of resources, with RCS being one such tool, that student midwives can reach out to, to maintain their personal wellbeing.

Share the midwifery experience of using the PMA and facilitating RCS with other university departments as good practice.

Continued evaluation of the ongoing provision of RCS in an educational setting.

Move to online RCS sessions in light of the current COVID-19 emergency situation.

> *"40% wanted more frequent RCS sessions, and some wanted to extend the length of the sessions"*

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Chapter summary

Key learning points


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LEARNING • SHARING • CARING