What Works Well at the Interface of Midwifery Care Handover

A Qualitative Study

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Abstract

Midwives have the necessary skills to provide care during normal childbirth. There can be times however during the birth, when the woman requires an intervention, which involves secondary services. It is at this point, that this midwife needs to consider transfer of clinical responsibility to an obstetrician as per the Ministry of Health (2012) Referral Guidelines. This transfer of clinical responsibility to the obstetric team may include a midwifery care handover to another midwife, who will then continue to provide the ongoing midwifery care to the woman in collaboration with the Obstetrician.

This research is focusing on what works well at the interface of that midwifery care handover. It is paramount that we get the midwifery care handover right, not only for the midwives involved in the process but also for the women, their babies and family/ whanau. Childbirth is at times an unpredictable journey and when the unexpected transfer of care happens, and the LMC midwife requests a midwifery care handover, the first step is to get the interface between the midwives right.

This qualitative study, using Appreciative Inquiry methodology, has been conducted to look at what works well for the midwives at the interface of midwifery care handover. Appreciative Inquiry was preferred, as it actively searches out the best of a situation, with a focus on what is good, strong and already working and what has been achieved. This methodology best fitted with the intent and approach needed to research the question: what works well at the interface of midwifery care handover.

Seven midwives participated in the study and the criteria for eligibility was that they had experienced handover of midwifery care more than once. These midwives were interviewed, and asked what they thought worked well for them at the interface of midwifery care handover. Using thematic data analysis, the following themes were identified; professional relationships, trust and respect between midwives, working collaboratively and effective communication. The midwives also highlighted that processes that were in place such as having one point of contact and the use of a communication tool to support effective communication. This all supported the interface of midwifery care handover.

This research was looking for answers from the midwives themselves, to gain an understanding of what worked well for them at the interface of midwifery care handover, so that this information could then benefit midwives, women and inform service provision.

What this research found was that the values of trust and respect amongst the midwives were the key elements to build the professional relationships that supported good communication and encouraged collaborative working relationships in the provision of safe midwifery to the women and their families/whanau.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

M. Norris

Margret Norris

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Acknowledgements

None of us got to where we are alone. Whether the assistance we received was obvious or subtle, acknowledging someone's help is a big part of saying thank you. (Harvey Mackay)

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Chapter One: Introduction

Midwives have the necessary skills to provide primary care during normal childbirth. However, there can be times during the birth when the woman requires an intervention that is outside the skill set of that particular midwife, or a complication develops that requires referral to specialist care. It is at this point that the midwife in her role as the Lead Maternity Carer (LMC) needs to consider transfer of clinical responsibility to an obstetrician (secondary services). Following the transfer of clinical responsibility to the obstetric team, a discussion then needs to take place as to who is the best midwife to continue providing the midwifery care in collaboration with the obstetric team. If the LMC midwife requests that a core midwife provides the ongoing midwifery care, then there will be a handover to a core midwife. This type of handover is referred to as a midwifery care handover, and this is the time when the two midwives interface. The term core midwives in New Zealand is used for the midwives that work rostered shifts to provide 24-hour care while women are inpatients in the maternity facilities. While handover can be a routine daily practice for core midwives in delivery suites, for the LMC midwife and the woman, it may be an unrehearsed experience. However, it is an important transition for all parties and it needs to go well. There are a lot of factors implicit in the midwifery care handover process that can cause frustration and tension, while these need to be acknowledged, the intention of this study is to focus on the positive aspects and build on these as a platform for the process of midwifery care handover to keep the woman at the centre of the handover safe.

Handover of care definition

The definition of clinical handover that was developed by the British Medical Association, Junior Doctors Committee in 2004, has been referred to many times in the literature by different researchers, in various clinical settings. This definition also describes the midwifery care handover process. Referring to handover as being; a transfer of professional responsibility and accountability for some or all aspects of care to another person or professional group on a temporary or permanent basis. (British Medical Association 2004, Australian Medical Association, 2006; Australian Commission on Safety and Quality in Healthcare, 2012, Munro, 2015).

Research Question and Aim of the research

Midwifery handover of care has been highlighted as a problem or concern amongst midwives; with the topic being raised as an area of contention at various midwifery forums such as Midwifery Leaders national meetings, local college of midwives' meetings, and education days. Many midwives saw handover of care as a process that needed addressing; however, these same midwives did not know how to define their concerns – or have any solution to their issues.

The research question asks: "What works well at the interface of midwifery care handover?" To answer this question, I interviewed seven midwives all who had experienced midwifery care handover more than once.

The aim of the research is to:

- Discover what midwives considered to work well at the interface of midwifery care handover for them.
- Identify what works well at the interface of midwifery care handover.

Impetus for this research

I have worked as a core midwife, a LMC midwife, and a midwife in management, but I am never far away from providing clinical midwifery care either as a LMC or supporting the core midwives. It is in these clinical and management midwifery roles that I experience the "fallout" of midwifery care handover. From my personal experience, there have been times when the handover went well, but there have been other circumstances, when I felt that the whole experience could have been done differently. Having had the opportunity to train as a midwife in a woman centred era not only brought the feminist out in me, it opened doors for me to be able to make changes. A willingness to want to make things work for the betterment of midwives and women, has been the motivator for me to undertake this study.

Justification for this research

As a midwifery leader who attends the District Health Board (DHB) Midwifery Leaders Forums, I have had discussions with my colleagues in relation to the issues around midwifery handover of care and noted that this is an area of frustration and contention amongst some midwives. Scott (2017) stated that the New Zealand College of Midwives were still receiving many calls to midwifery advisors about tensions regarding hand-over responsibilities between LMCs and core staff and this

hasn't changed from previous years. When there is disharmony between the midwives there is the potential to increase risk for the woman at the centre of the handover. Spranzi (2014) found that although there is strong evidence linking poor handovers to poor outcomes there is limited research with a focus on handover in the labour ward. The issues that sometimes arise for some midwives at the interface of midwifery care handover, need to be acknowledged and addressed, and that is what makes this research topic important.

The observational study by Yet, Taylor, Knott, Dent, & MacBean, (2007), looking at handover in the emergency department of three large metropolitan hospitals, concluded that deficiencies in handover processes do exist, especially with communication, management of patients, and poor handover processes; and this has an adverse effect for health practitioners and patients. They also stated that no single handover system would meet everyone's needs, but handover is an area requiring further research.

My Pre-Assumptions

To undertake this study, I needed to fully understand my own position regarding the research question and for this purpose my supervisors interviewed me and provided feedback on my responses. My supervisors and I then spoke about my awareness regarding handover of midwifery care. I did have a strong viewpoint about midwifery care handover, and that every LMC midwife has the right to handover and core midwives should be facilitating the handover. For this reason, to ensure that my views and opinions did not influence the study, I had to learn to listen and focus on the story that the midwife was telling, and not let my own view point interfere in the process. To safe guard myself I ensured that at no point in the interviews did I create an opportunity for the midwives to ask me about my experience or views of midwifery care handover. Doing the thematic data analysis, I found I became totally absorbed in the midwife's story and her experience and there was no room for any personal train of thoughts to alter or devalue her experience. Interviewing the midwives away from the busy delivery suites was a conscious choice for me not to get involved in their work environment, which as a midwife it is very easy to do. Such an environment would also bring current issues of the day rather than a reflection of when things did go well for them at the interface of midwifery care handover. At the same time, I needed to remind myself I was a midwife researcher, not a clinical midwife, which meant I was there to discover and

learn from the midwife being interviewed and not add my own opinion or ideas to their situation at the time.

New Zealand Maternity Model

This explanation is for the reader to gain an understanding of how the New Zealand maternity model of care works as this builds the picture for midwifery care handover. The context in which the midwives work in New Zealand is based on our unique model of maternity care. The amendment to the New Zealand Nurses Act 1990 returned autonomy to midwives and meant they could provide midwifery care without the supervision of a medical practitioner (Dept. of Health, 1990). Further changes and choices for women came in 1996 with the introduction of the Lead Maternity Carer (LMC) model. This then meant that the woman had one person coordinating her care during pregnancy. A LMC can be a midwife, obstetrician or a general practitioner with a Diploma in Obstetrics or equivalent as determined by the NZ College of General Practitioners. (Section 88 of the NZ Public Health and Disability Act 2000, 2007). Section 88 is the contract between the LMC and the Ministry of Health which allows for payment of maternity services provided. It is the woman that chooses her LMC, and then they work in partnership throughout the pregnancy, labour and birth, and for both the woman and the baby until the baby is 6 weeks old. It is to be noted that it is midwives that provide the majority of primary maternity care in the community as LMCs, however, midwives also staff the maternity hospitals. A midwife may practise in any setting, including the home, the community, hospitals or in any other maternity service. In all settings, a midwife remains responsible and accountable for the care she provides (Midwifery Council, 2010). Midwives whether they are LMC or core, attend every birth in New Zealand, not just the low risk births (Skinner & Fourer, 2010). The Midwifery Council 2016 Workforce Survey shows that 32.7% of the midwives are self- employed LMCs and 50.7 % are core midwives.

The Midwifery Partnership

The partnership model in the New Zealand midwifery context is one where the midwife and the woman establish a professional relationship that supports the health and well-being of the woman through information sharing, recognising and respecting decision making, self-determination and informed choice that the woman determines for herself and her baby (Guilliland&Pairman,2010).

Referral Guidelines: a reference for handover

This document not only serves as a resource to inform the maternity providers when a woman would be better managed by or in conjunction with another provider, but also to also provide an easy reference and pathway for the LMC midwife to follow and discuss with the woman. The *Guidelines for Consultation with Obstetric and Related Medical Service (Referral Guidelines)* is a Ministry of Health document that was first introduced in 2002 as an appendix to the Maternity Services Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000. (Appendix A). This document is often abbreviated and referred to as the Referral Guidelines. The purpose of these guidelines is to provide best practice in maternity care, and were based on expert opinion and available evidence. The intention was that the guidelines would facilitate consultation between the midwives and the obstetricians to integrate care and to provide confidence to providers, women and their families. These guidelines were updated in 2012 with the principles of intent remaining the same but with the introduction of process maps and a change in categories from levels 1-3 to primary, consultation and transfer. The woman, her baby and family/whanau remain at the centre of the decision- making and there is full and timely communication between the practitioners. The LMC may refer the woman for a consultation with another practitioner and this does not always result in a transfer of clinical responsibility. The referral could be for an assessment, advice, or an opinion to the woman and her LMC regarding the ongoing management and care provided by the LMC. A key point is that when the LMC transfers clinical responsibility for care to another practitioner, and, where appropriate and with the agreement of the woman, the LMC can remain and continue to provide the midwifery care that is within their competence, and with the support of the hospital team (MOH Referral Guidelines, 2012). Handover of care can occur at any stage of the continuum of the woman's pregnancy but for this study the focus is on handover of care for the labour and birth as this has been raised as an area of contention by some of the midwives that I have spoken to prior to undertaking this research.

How the Core Midwife Becomes Involved.

There is a three-way discussion that takes place with the woman, the specialist, and the LMC, regarding diagnosis, treatment, and care plan. This discussion includes the ongoing role of the LMC, and whether all care, including midwifery care is transferred to the specialist and the DHB midwifery team. The decision for the involvement of the DHB midwifery team is made by the Obstetric Team if the LMC midwife who is handing clinical responsibility over to an obstetrician is not going to provide the ongoing midwifery care for that woman.

The process map (Appendix A) of the Ministry of Health (2012) *Guidelines for Consultation with Obstetric and Related Medical Services. (Referral Guidelines)* states that the ongoing roles of the LMC and DHB midwifery team are discussed and documented; it would be at this point that the midwifery care handover takes place.

What is Midwifery Care Handover?

If the LMC midwife is no longer providing the midwifery care in collaboration with the obstetric team, it is then that there is a midwifery care handover. A LMC midwife does not hand clinical responsibility directly to a core midwife, the LMC midwife hands over clinical responsibility to the obstetric team. Following the obstetric team handover, the midwives interface to do the midwifery care handover. The core midwife then works in collaboration with the obstetric team.

Gilkison, McAra-Couper, Fielder, Hunter and Austin, (2017) stated that the role of the core midwife is one that attends the women, when her risk status alters, and her primary care midwife transfers the care.

Diversity of midwifery roles

There are the statements around the midwifery role itself that clearly separates out what a core midwife does and what an LMC midwife does. Guilliland and Pairman (2010) stated that when the core midwives are working with other practitioners, they would be bringing elements of the midwifery philosophy to their service, but they will not be practising midwifery in its full tradition. I do not believe Guilliland and Pairman (2010), had intended that the core midwives would see this as a criticism

of how they practise. However, core midwives at the time of midwifery care handover have no option but to work under the direction of the obstetric team and they cannot always guarantee their voice will be heard. Guilliland and Pairman (2010) did go on to say that there was also an attempt at that time, by the New Zealand College of Midwives to ensure that midwives working in the facilities continued to have their autonomy and continuity of midwifery, but there had been a level of resistance from some hospital midwives and their managers to the concept. Dixon, et al (2017) discussed the need for further work to explore the midwifery perception of facilitators and barriers to autonomy within the hospital environment. While these issues may seem irrelevant to the debate around interface at midwifery care handover, they are relevant as they underpin the working conditions for the core midwives and some of the attitudes that have an influence over their work environment that creates tension amongst the midwives.

Historically there has been the belief by the core midwives that the focus by the Midwifery profession has been on the LMC role, and for a very good reason, there was a need to re-establish the midwifery profession after the change to the Nurses Amendment Act, (1990) and move away from the medical maternity model that was in existence. Midwives had been given back their autonomy, and midwives left the facilities in droves to establish their midwifery practices. In doing so, the role of the core midwife was perhaps seen as a lesser midwifery role than that of a LMC midwife in the eyes some midwives.

However, Guilliland and Pairman (2010) presented a case that the core midwifery role had been developed by the midwives themselves in response to the LMC role, and that the interface between the midwives was now integrated and the environment supported both roles. The role of the core midwife in caring for women when the LMC midwife's handover means that core midwifery is fundamental to the effective functioning of New Zealand maternity services. (Gilkison et al, 2017) Whether the midwife has chosen to be an LMC or a core midwife is irrelevant but what is important is that at the time of interface for midwifery care handover both roles are acknowledged.

Primary or Secondary Midwifery Care

There is still a conversation that is heard in the workplace which suggests that the boundaries between primary care and secondary care are blurred. Primary midwifery care is the care that a LMC midwife provides to the woman and does not

require a medical intervention. Secondary midwifery care is when there has been a consultation with an obstetrician which has resulted in a transfer of clinical responsibility to the obstetrician and the midwifery care is then provided in collaboration with the Obstetrician. On reflection, the confusion is more likely to be around the procedures the midwife has chosen to provide in consultation with a specialist during labour and birth. The LMC midwife for example, provided she has the appropriate clinical competency, manages the woman with an epidural in labour, or syntocinon augmentation. The LMC midwife declares these choices of practice in her Maternity Services, Section 88 (2007) Generic Access Agreement, she has with the facility. If the midwife has chosen not to provide these elements of care to the woman, this then results in a handover of midwifery care following a consult with the obstetric team.

The Chapters

Chapter Two: Literature review.

This chapter presents the literature that is most relevant to this topic. The themes that emerged from the literature review undertaken for this research centred on communication, communication tools, inter-professional collaboration, trust, respect, accountability, and lack of a standardised tool or process. There is a strong link in the literature between relationships and communication, and the need for trust and respect to enable the collaborative working relationships. Interwoven amongst these themes is an overarching message that a poor or ineffective handover has an increased risk to the patient, and that patient handover is a key process to improve patient safety.

Chapter Three: Methodology and methods

This chapter includes a description of Appreciative Inquiry the methodology that was used, and will offer an explanation as to why it was considered the most appropriate for this research. Included in this section is methods which includes recruitment of participants, ethics, data collection and data analysis.

Chapter Four: Profiling midwives' employment

Midwives can work in a variety of settings not just in a hospital, and the midwives in this study demonstrate the flexibility and diversity that reflects midwives working environments. Even in this small cohort of midwives there is a wide range of experience and work places.

Chapter Five: The impact of relationships at the interface of midwifery care handover.

The midwives identified that relationships were one of the most important things to them at the interface of midwifery care handover. They placed value on trust and respect, building relationships, and what influence those relationships had on the handover process.

Chapter Six: Processes and what works at the interface of midwifery care handover.

This chapter explores the processes that the midwives recognised as having made a difference for them at the interface, and discussing the impact they have on midwifery care handover.

Chapter Seven: Discussion

In this chapter, the findings of the study are discussed along with the limitations of the study and implications for practice, ongoing education, and further research are discussed.

Summary

The interface at midwifery care handover is a time when two midwives come together to share a woman's information and one midwife transfers the midwifery care to another midwife. However, for this to happen there needs to be a process involving the obstetric team and the LMC midwife transferring the clinical responsibility to the obstetric team. This study looks at what works well at the interface of midwifery care handover. This chapter sets the scene with an explanation of how midwives work in New Zealand and what midwifery care handover is Included is a section on the Ministry of Health Referral Guidelines which informs the role of the core midwife once a LMC midwife has transferred clinical responsibility to the obstetric team. This has been followed by a brief outline of the chapters.

<center>**Chapter Two: Literature Review**</center>

Introduction

This research is looking at what works well for midwives at the interface of handover of care. Midwives have the necessary skills to provide care during normal childbirth. There can be times during labour when the woman requires an intervention that is outside the skill set of that particular midwife. It is at this point that the midwife needs to consider handover of care to an obstetrician who will resume the clinical responsibility for the woman; however, this can also include handover to another midwife who will provide the ongoing midwifery care. Midwifery care handover can also occur when a midwife working as a LMC is taking time out from her practice and is handing over the care of the woman to another midwife who will be covering for her in her absence.

While handover of care should be a smooth transition of information sharing with no increased risk to the woman, this is not always the case; as has been reported by the New Zealand Health and Disability Commissioner in recent years (HDC00876, HDC00259, HDC0088). These three cases reviewed by the Health and Disability Commissioner (2013-2015) had adverse outcomes and in each of these cases it was cited that handover was inadequate, untimely or incomplete. Because of what was ''reported'' in these three cases, to be a poor or inadequate handover from one midwife to another midwife, the handover was seen as a contributing factor for the three mothers with their loss of their babies.

To explore, and understand, what works well at the interface of midwifery care handover, there needs to be an explanation of the uniqueness of the New Zealand model of maternity care, and how midwives work in this model. This explanation will be covered in the background section of the literature review.

The Literature Search

Having access to the AUT library, an electronic search was undertaken of the databases: Science Direct, ProQuest, CINAHL, and Bio Med Central, for the period January 2005 to December 2015. The Google Scholar internet search engine was also used to look for any relevant studies. The initial literature search was based on looking at handover of care between midwives.

Using the keywords and phrases: 'handover of midwifery care', 'handover between midwives', and 'handover between primary and secondary maternity care' resulted in very limited literature. These same findings were echoed by Spranzi (2014) in a narrative synthesis literature review. Spranzi was assessing the current knowledge on clinical handover on the labour ward in maternity units. The literature review for Spranzi's study started out with a total of 26 articles, but had to exclude 13 as they did not focus specifically on the topic of handover on the labour ward. Eventually only 9 studies were included in the narrative synthesis. Spranzi concluded that despite the overall growing interest in clinical handover and the strong evidence linking poor handover to poor outcomes, there was limited research focusing on clinical handover on the labour ward. (Spranzi, 2014)

Due to the limited availability of literature on the specific topic of midwifery care handover, the decision was made to widen the search to include handover in all clinical setting. This resulted in a greater number of articles available for review. Consideration was then given to the available literature and how it could be applied to midwifery practice in a New Zealand setting, and then the relevance of the literature to the question "what works well at the interface of midwifery care handover?" The wider search resulted in available literature regarding different professionals and clinical settings, where handover was identified as a critical process that had an impact on the clinicians and patients. This included nurses and doctors in emergency departments, anaesthetists, nurses in ward situations, and midwives to doctors in maternity settings. Handover between midwives has not been widely documented or researched.

Manser and Foster (2011) produced a paper titled *Effective handover communication: An overview of research and improvement efforts*. Their focus was on handover situations relevant to anaesthesiology, but they also found that they needed to use examples from other clinical settings to compensate for lack of studies for their specialty. Thus, despite the evidence that clinical handover is a safety issue for patients; it is still an evolving area of research to establish the evidence base for effective handover practices. Petersen et al. (2013), in their qualitative study looking at what makes handover communication effective, also found there was very little research to identify best practices.

Background

As with many other professions, New Zealand midwives graduate with a skill set that they can go on to extend and build on through further education or by working with other experienced midwives who share their knowledge and skills, thereby growing the knowledge base of other midwives. The Midwifery Council have stated in their Midwifery Scope of Practice and qualification Notice (2010), that a midwife "may practice in any setting, including the home, community, hospitals or any other maternity service". However, regardless of the setting a midwife remains responsible and accountable for the care she provides. The unique New Zealand maternity service gives New Zealand registered midwives options around their employment whether she will be a core midwife or a Lead Maternity Carer midwife in the community.

Scope of Practice: Midwife

The Midwifery Council is the regulatory body for the midwives that practice in New Zealand. They have the responsibility of protecting the health and safety of members of the public by providing mechanisms to ensure that midwives are competent and fit to practise midwifery. Pursuant to section 11 (1) of the Health Practitioners Competence Assurance Act 2003, the Midwifery Council of New Zealand (2010) specifies the Midwifery Scope of Practice as follows:

> *A midwife works in partnership with women on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.*
>
> *When women require referral, a midwife provides midwifery care in collaboration with other health professionals.*
>
> *A midwife may practise in any setting, including the home, the community, hospitals or in any other maternity service. In all settings, a midwife remains responsible and accountable for the care she provides.*

Regardless of the role that the midwife has chosen to work in, her scope of practice remains the same; all midwives have the same scope of practice, but it will change how they work within the general scope. Calvert, Smythe, and McKenzie-Green's (2017) study, looking at how midwives maintain their competence, stated that midwives engage in development that enable them to provide the appropriate care to mothers and babies, and because of this they can develop expertise in their chosen areas of midwifery.

Clinical Handover

The definition of clinical handover that was developed by the British Medical Association, Junior Doctors Committee in 2004, has been referred to many times in the literature by different researchers, in various clinical settings. Referring to handover as being; a transfer of professional responsibility and accountability for some or all aspects of care to another person or professional group on a temporary or permanent basis. (British Medical Association 2004, Australian Medical Association, 2006; Australian Commission on Safety and Quality in Healthcare, 2012, Munro, 2015). Raduma-Tomas, Flin, Yule and Williams (2011) go one step further and state that it is also a high-risk process where communication failures can lead to adverse outcomes that could have been prevented.

Bruton, Norton, Smyth, Ward and Day (2016) undertook a qualitative study looking at handover experiences for nurses, also used the 2004 definition published by the British Medical Association and stated it applied equally to nursing handover. Croos (2014) also quoted the BMA 2004 article when looking at clinical handover in a respite care setting and Spranzi (2014) used the same definition on a labour ward. Manser and Foster (2011) echoed the definition when they were looking at handover relevant to the specialty of anaesthesiology. Munro (2014) a midwife researcher from Ireland, also used the same definition when looking at the implementation of a national guideline for handover following a tragic maternal death in a hospital in Galway. O'Connell, Ockerby, and Hawkins (2013) introduced handover as a process of communicating patient information to another group of health professionals who will then be responsible for the ongoing care. In addition, they stated that it is a fundamental component of everyday clinical practice and that it is essential to ensure patient safety. As Broekhuis and Veldkamp (2006) state that the primary objective of a clinical handover process is "to provide and receive accurate patient information to provide the right kind of care". It is an essential process routinely done many times a day, and can be time restrained which then increases the risk for the patient and mistakes can be made resulting in major impacts. Jorm et al. (2009) echoed similar sentiments that because this is such a universal process it can sometimes be deemed as a mundane task; and handover is an area that is often over looked until something goes wrong, it is only then that the process is considered to be inadequate. Scovell (2010) concluded that the importance of handover is too often ignored to the detriment of colleagues and patients. Raduma-Tomas et al.

(2011) concluded, with their study, that a better understanding of handover would help to highlight communication failures and enable more effective approaches to having a standardised process and prevent risks.

Johnson and Barach (2009) stated that clinicians and researchers both agreed that handovers served as the basis for transferring responsibility and accountability for the patients across disciplines and across settings, and that the information at the time of the handover is critical for patient safety. However, this is not what Chin, et al (2012) found when they explored the maternity clinician's perceptions of transfer of responsibility and accountability for patients in relation to clinical handover in a tertiary Australian birth suite. This study included midwives, nurses and doctors. What the research found was that most participants did not automatically connect maternity handover with the transfer of responsibility and accountability. They concluded at the time of handover everyone needs to agree upon responsibilities and accountability and that this is a keystone to safe clinical care (Chin et al,2012).

Frameworks for Handover of Care in Maternity in New Zealand

The handover process of the woman in the New Zealand model of maternity care is guided by the Ministry of Health (2012) *Guidelines for consultation with obstetric and related medical service*. This document is often abbreviated and referred to as the "Referral Guidelines". The purpose of these guidelines was not only to improve quality and safety but to also "promote and support coordination of care across providers" (Ministry of Health, 2012, p.1). These guidelines are relevant not only to the LMC but also to any other health provider that needs to become involved in the woman's maternity journey. Following a referral to the specialist and if a decision has been made and the woman has consented to the transfer of clinical responsibility, there is to be a three-way conversation between the woman, the specialist and the LMC regarding not only the ongoing management for the woman, but also the role of the LMC midwife and the decision then needs to be documented. (Ministry of Health, 2012, p.13). The transfer of clinical responsibility for care is in place until the transfer is made back to the LMC if and when appropriate. Skinner (2011) looked at how midwives manage risk and the use of these referral guidelines. What was documented in the limitations of this study is that the attitudes of core midwives to the referral guidelines and the continuity of midwifery care had not been examined. Skinner also stated that further work was needed to look at how the

current model of care works and that all midwives, regardless of the setting, support each other when women in their care are experiencing complexity.

The other situation when midwifery care handover takes place that is not covered in this study, is when a LMC midwife is handing over to a locum midwife or a colleague while she is absent for whatever reason from her practice. This can be for a short period of time or a fixed period while she is on annual leave, for example. There is very little documented around the process of handover used in these circumstances, and one can only assume that each midwife will have her own method of handing over.

Themes that Emerged from Literature Review

The themes that emerged from the literature review undertaken for this research were communication, communication tools, inter-professional collaboration, trust, respect, accountability, and lack of a standardised tool or process. There is a strong link in the literature between relationships and communication, and the need for trust and respect to enable collaborative working relationships. Interwoven amongst these themes was an overarching message that a poor or ineffective handover has an increased risk to the patient, and that patient handover is a key process to improve patient safety.

Communication

Communication or lack of communication has been referred to throughout the literature, and has strongly been linked to the outcome of the process for handover. Basically, handover cannot happen unless there has been some form of communication. The communication can be in a written form or verbalised, but, what the literature states is that, it is the quality of the communication that impacts on the outcome of the handover. Borrelli, Walsh and Spiby (2016) concluded in their qualitative study that respectful and efficient handovers between midwives are crucial in reducing risk when continuity of carer cannot be guaranteed. Midwives need to pay attention to how they handover especially around the communication and that the woman and her support people are involved and respected. The Health and Disability Commissioner's (2014) Annual Report has "communication" noted as the second primary issue complained about, with professional conduct being the

third issue and treatment as the most common. On reflection, these three issues would be interlinked in any health setting and in a handover of care process.

So, what does effective communication look like in a handover setting? There is a common understanding that handover communication is about sharing or transferring information amongst healthcare providers, and there are many articles available on the consequences of negative or inadequate handover. However, there is little research that identifies best practices (Petersen et al., 2013).

As stated by Hastie and Fahy (2010), in their interpretive interactionism research, poor communication is the most common cause of preventable events in hospital. They also added that major enquiries into maternity services continued to find that ineffective, absent, or rude communication is usually associated with poor outcomes for women and babies; and despite these understandings the same behaviour continues to happen. Hastie and Fahy called for an urgent need to both investigate the causes and possible cures of ineffective communication, and foster collaboration between the professionals providing maternity care. The conclusion of their study found that the participants were happier following engagement in a shared setting that took the focus away from individual skills of the doctor or midwife and created an environment that encouraged the development of mutual trust and respect to improve communication and collaboration (Hastie and Fahy, 2010).

Berridge, Mackintosh, and Freeth (2010) conducted a longitudinal mixed method study over a two-year period on four different sites in England, looking at communication within delivery suite teams. They purposely selected their research sites so that they had variation in the maternity services being provided. Their objective with this study was to explore the nature of intra- and inter-professional communication in delivery suites, with a focus on patient safety. In this study, they concluded that communication underpinning collaboration requires the exchange of information, and in turn collaboration was linked to better care. They stated they observed how the collegial atmosphere and productive collaboration helped to support safe care and goodwill working beyond roles or employment requirements. However, they also observed the effects of workload pressures and what had initially been hypothesised that the communication styles would vary as workload pressures fluctuated instead found that the persistence of communication styles indicated strongly habituated behaviour, which might support or inhibit patient safety. In other

words, regardless of the workload pressures, communication style was based on what was the norm in that delivery suite. This study also acknowledged the delivery suite environment is very different to other areas in the hospital, where the staff involved have clearly defined roles and established lines of command (Berridge et al, 2010). Delivery suite environment on the other hand features more complex interactions and relationships due to the autonomy of the professionals in the group and there are different models of care and contested role boundaries – hence, a need for closer collaboration and co-ordination when communication occurs. One of the conclusions from their study was that further research was needed to explore the impact of safety solutions such as the Situation, Background, Assessment and Recommendation (SBAR) tool on communication processes and local culture and quality of care (Berridge et al, 2010).

Manser, Foster, Gisin, Jaeckel and Ummenhofer (2010) introduced their study with the statement that there has been increasing recognition that a lack of training on teamwork and effective communication, combined with a lack of formal systems, impede the good practice necessary to maintain high standards of care in all healthcare areas. They referred to handover as handoff. Handoff being the point in time when the patient is handed over to another professional who was then accepting care for the patient. What they found is that most of the research is based on descriptive studies and few studies have evaluated interventions to improve handoff quality. Their study identified three key factors: information sharing, shared understanding, and working atmosphere as a prediction for the quality of the handoff. While their study provided no specific tools for handover, what it did do was evaluate the quality of handoff and identify the areas that need consideration when looking at handover processes in a specific area. The authors also suggested looking at other industries and their experiences to improve processes. (Manser et al, 2010).

Bruton et al., (2016) found in their study looking at nursing handover, that there were communication problems within the clinical team and this was identified not only by the staff but the patients also. They concluded that it may not be necessary to introduce a standardised handover format, as every area has its own specialty; more important was that the handover process was agreed by all the professionals that would be using it in their own areas.

Communication Tools

The use of communication tools, such as SBAR (Situation, Background, Assessment, Recommendation) or a variation of ISBAR (Identify, Situation, Background, Assessment, Recommendation) have been debated by many researchers when looking at patient safety and effective communication at the time of clinical handover. Munro (2012) discussed a hospital in Ireland implementing the use of a communication tool following a tragic maternal death in which poor communication was identified as one of the contributing factors. Bagnasco, Tubino, Piccotti, Rosa, Aleo, Di Pietro et al. (2013) recommended that tools such as SBAR were identified as being key in mitigating risk and memory failures, and that they can uniform communication styles. Zikhani's (2016) seven step pathway for preventing errors in healthcare also endorses the use of communication tools such as SBAR, as being one of the most effective ways in reducing communication errors.

 Becket & Kipnis (2009) verified that SBAR used in isolation increased consistency of the handover but at that time there were no studies that demonstrated improvements in patient outcomes, collaboration or teamwork. What their study did confirm however, was that when SBAR was used in conjunction with collaborative communication education, statistically significant changes were noted in communication, teamwork and safety climate.

Spranzi (2014) reported that SBAR was being used in the National Health Service in the UK as it had been introduced as quality and service improvement in 2008. However, Spranzi (2014) noted there was only one study at the time by Poot, de Bruijne, Wouters, de Groot, and Wagner (2014) that specifically looked at the use of SBAR in a maternity setting. Poot et al. (2014) concluded that the handovers in maternity were at risk due to inadequate situation assessment because of variations and limitations in their handover communication and process, and that the staff member receiving handover showed a lack of awareness that patient safety is threatened during handover. Poot et al. (2014) also identified there needed to be a willingness and acceptance that change was required to improve the current handover practices and their needed to be reflection and training.

Blom, Petersson, Hagell, and Westergren (2015) also determined, like other studies, that the SBAR communication tool is an effective communication tool to enhance patient safety. However, to successfully implement a communication tool like SBAR into routine healthcare, the authors believed there needs to be the willingness

to change and improve communication, as well as respect amongst all the health care team. Munro (2015) recommended that clinical handover needed to be incorporated within the programmes at all levels of professional education and this included the introduction of a communication tool. Ting, Peng, Lin, Hsiao (2017) concluded that the SBAR technique is a feasible tool for communication between the staff in the obstetric department. Following their evaluation of the tool that there was significant improvement in the teamwork, job satisfaction, safety attitudes and working conditions after the implementation of SBAR into the department.

Collaboration

From the literature review it is evident that to have collaboration, there needs to be good communication. The two principles need to go hand in hand amongst the maternity service practitioners, but as Reiger and Lane (2009) concluded, in their qualitative case studies, another key factor is "professional courtesy". Their study looked at effective collaboration between midwives and doctors and clearly demonstrated that while there is rhetoric about working as "teams" and multidisciplinary collaboration, what was needed was the basic qualities of interpersonal interaction. These qualities included common civility or "good manners" where people acknowledged each other, did not get abusive in stressful times, were polite when they were asking for things and, in general were caring for fellow workers regardless of their occupational status. A very strong statement in their conclusion was that "professional courtesy should be demanded in meetings as well as clinical settings and senior medical and midwifery staff must model this so that there can be a mutually respectful professional cultural." (Reiger & Lane, 2009, p.323). While some of the midwives and doctors recognised the need for change, the authors also noted for this to happen, that it wasn't just about changing hierarchical outdated professional relationship systems, or the resistance to change by doctors, there was also some midwives preferring to work in an "obstetric nurse" role whereby they take on less responsibility and less autonomy.

Downe Finlayson and Fleming (2010) stated that the issue of collaboration is high on the health care agenda in many countries and, in maternity care, collaboration is particularly important for pregnant women as they cross over from low to high risk and geographically move to birth. The authors went on to say that it is at these boundary points where differing philosophies around the provision of care may lead

to miscommunication and tension, and even antagonistic behaviour. What Downe et al. (2010) also noted, when they undertook their study, was that there had been very little discussion around the impact of collaboration within a maternity setting. While Hastie and Fahy (2010) demonstrated in their study that "turf wars" are still common between midwives and doctors, however collaboration between the two did occur and their conclusion to enhance collaboration was about changing structures and policies that would promote natural dialogue between the two parties. This was also what Beasley, Ford, Tracy, and Welsh (2012) concluded in their retrospective quality analysis study in the Royal Hospital for Women in Sydney, Australia. They looked at the effectiveness of collaboration between midwives and obstetricians for a 12-month period, November 2009 to November 2010. They concluded that when there are indicated risks during pregnancy, a collaborative practice between midwives and obstetricians is achievable. However, for collaboration to be successful there needs to be shared decision-making and each party holding equal power in a non-hierarchical model (Beasley et al., 2012). This can be a challenge, particularly in a handover of clinical care process.

Following a survey of midwives, Skinner and Foureur (2010) concluded, in their New Zealand study, that although there can be room for improvement, in general midwives felt that they did have successful collaboration relationships with the obstetricians. This study asked midwives about their consultation data and their transfer of responsibility/referral data. What the authors also found was that there were no studies available that addressed how improved collaboration might be promoted at the primary and secondary interface between midwives and doctors, and that their study provided a basis for a national debate on the topic. While thereis consensus in Skinner and Foureur's (2010) study that midwives felt they did have a successful collaboration with obstetricians, the follow up study by Skinner (2011) stated that further work was needed to examine how all midwives, regardless of the setting, work collaboratively to support each other, especially when the women's care becomes complex.

Hutchinson, et al., (2011) published a paper marking the 36th year of collaboration between certified nurse-midwives and obstetricians in a San Francisco General Hospital, and commented that despite professional differences collaboration has thrived. This was mainly due to mutual respect and shared vision. The authors stated

it has not been without challenges but generally conflict had been resolved through direct communication and revisiting practice guidelines which ensured a collaborative relationship. They gave an example of where resolution was achieved following conflict between the two professional groups and how adoption of a midwifery-guided practice was supported and endorsed by the obstetricians (Hutchinson, et al., 2011).

Watson, Heatley, Kruske, and Gallois (2012) conducted an online and paper-based four-month survey in Australia, and concluded that collaboration means different things in practice to the different professions. They added that for collaboration to be genuinely adopted there needs to be a transformation in the way maternity care providers see each other's role, and their philosophy of care, and a key aspect would be the embedding of collaborative practices into their workplaces. This would include acknowledging that in maternity care effective communication between all the care providers is also linked to collaborative care. While this study only had a small sample size, results did suggest clear directions for future research.

Break down in collaboration is not always with the relationships between medical and midwifery professionals; it can also transpire between midwives themselves as the study by Harris, et al., (2010) showed. This qualitative study completed in Scotland demonstrated that communication and collaboration was not just an issue between midwives and obstetricians, but also between the midwives themselves. Seventy-two staff, predominately midwives, were interviewed from 10 maternity units across the maternity spectrum, with a focus on rural practitioners. The study illustrated the role the midwives' attitudes had on the handover process (Harris et al., 2010). Good working relationships is an important factor in the handover process to ensure the safety of the woman; at the same time, it is essential that there is a professional relationship with colleagues, where one party is not left feeling undermined and incompetent. This study concluded that the contact of colleagues in urban units impacted on the rural midwives' practice, and the urban midwives had a viewpoint about rural midwives, but the same could be said vice versa whereby the rural midwives stereotyped the urban midwives.

Hastie and Fahy (2010) also concluded that interventions to enhance inter-professional collaboration need to start with changing organisational structures and policies to promote easy opportunities for natural dialogue between doctors and

midwives. What was noted in this study was the negative behaviour was not just between the doctors and the midwives, but hierarchical medical domination over the midwife, when the doctor and the midwife were both females. Similarly, negative behaviour ensued when the junior registrar was a female and had a negative interaction with a female midwifery manager. (Hastie and Fahy, 2010)

Hutchinson et al. (2011) published a paper marking the partnership between the obstetricians and the nurse-midwives. What they found was that despite the differences in the medical and midwifery models of care, collaboration has thrived in large part due to mutual respect for differences and a dedication to common principles.

Reiger and Lane (2009) looked at how midwives viewed each other. What came through from the interviews was that the midwives needed to value each other and acknowledge the different levels they all worked at, rather than just be critical all the time. They also stressed collegiality and that a good midwife was non-judgmental.

Summary

The literature for this study has covered a broad clinical aspect as midwifery care handover is not a well-researched area of clinical practice. As Spranzi (2014) concluded, handover is considered to be the most dangerous procedure in a hospital setting and there is strong evidence that it links with poor patient outcomes. Despite the growing interest and strong evidence, there is still limited research focusing on clinical handover on the labour ward. Themes that emerged from the literature review likens the clinical handover in maternity labour ward with other areas such as the accident and emergency department or intensive care. The maternity delivery suite is viewed as a high-risk area and processes such as a communication tool, building of relationships, and working collaboratively could be of value to support the clinical handover process for the maternity service. While there is plenty of evidence that differing philosophies can lead to miscommunication, tension or even antagonism, there is also evidence that resolving these issues will lead to better collaboration, and will influence the outcome for women.

Chapter Three: Methodology and Methods

Methodology

In this first part of the chapter, I discuss the methodology used for the research and the rationale for the choice of Appreciative Inquiry (AI). The decision was always for this research to be qualitative and, at the same time, have a positive focus. The use of AI does not exclude participants from relating their negative experiences; what it does do, is get the participants to bring their focus back to the positive aspects of the discussion. By doing this, a solution can then be explored through engagement with the participants and bring about positive change. Included in the discussion is an introduction to AI and rationale for the use of this methodology. A description of what underpins the application of AI, including the AI 4-D cycle is offered; along with an explanation as to why it is important that the researcher understand the concepts and processes when using this methodology.

Choosing a Research Methodology

The aim of this research was to identify factors that midwives considered to have worked well for them at the interface of midwifery care handover. Midwifery handover of care has been highlighted as a problem or concern amongst midwives; with the topic being raised as an area of contention at various midwifery forums such as District Health Board's Midwifery Leaders national meetings, local New Zealand College of Midwives meetings, and education days. Many midwives saw handover of care as a process that needed to be addressed however, these same midwives did not know how to define their concerns – or had any solution to their issues.

The focus for the research was on what worked well for midwives at the interface of midwifery care handover, but any factors raised by the midwives that can have an impact on the handover process needed careful consideration. Whether it be the distance midwives had to travel to handover, or the process used for handover by the facility to which the midwife was transferring. Not everyone had issues regarding handover of midwifery care. However, listening to midwives around New Zealand, I recognised that while some things were working, other aspects were not

as successful or consistent in providing successful transfers of care. The variations seen in the handover process and expectations were dependent on the individual midwife giving or receiving the handover; there was no consensus or consistency when midwifery handover of care was being discussed with midwives in their practice settings.

Midwives had raised the issue of handover of midwifery care; thus, it seemed appropriate that the research was carried out by a midwife. Dixon & Guilliland (2010) stated that research is essentially about learning, developing, and understanding ideas that can provide or expand our knowledge of the world, and midwives undertaking research look at the world from a midwifery perspective and ask questions in a different way to other researchers. Using a midwifery lens to undertake this study would keep the midwifery practice of handover as the focus for the researcher.

When this study was proposed, three methodologies for qualitative research were reviewed; grounded theory, phenomenology, and ethnography. The principles of all three methodologies were appraised and each methodology was then applied to the intent of the research. For this study, the researcher wanted to learn from midwives what worked well for them at the point of midwifery care handover; whilst keeping the process of participation both a positive one and an opportunity for learning for all midwives. After discussion with my supervisors, and the suggestion that I look at AI, I researched this relatively modern methodology. In comparing it to other qualitative methodologies, I concluded that this was the approach on which I wanted to base my study. The primary reason for this decision was that in contrast to other qualitative methodologies, AI actively searches out the best of a situation, with a focus on what is good, strong, already working, and has been achieved (Carter, 2006). AI is research in which the midwives could participate, and consider solutions to the issues raised around midwifery care handover. The researcher concluded that this methodology had the best fit with the intent and approach needed to research the question of what works well at the interface of midwifery care handover.

Introduction to Appreciative Inquiry (AI)

AI uses an approach that looks at what is already in place and what the real experience and history has been for the people involved, with a view to identifying what can be repeated for the success to occur again and again. (Whitney and Trosten-Bloom, 2010) Using AI enables midwives to tell the researcher what they see as working well or what would be ideal in the situation of handover. In doing so, AI allows them the opportunity to imagine the ideal handover process and thereby contribute to changing the process in a way that will benefit all participants and stakeholders in the transition of care.

AI focuses on analysing strengths, by asking participants what they consider to be working well for them, and why they think it worked well. It is about building on what is already working well, rather than trying to fix something that is not working. However, this methodology does not exclude the participant from relating negative situations, as AI is about discovering and understanding the reality for the person being interviewed. It is imperative that participants use their own words and expressions to describe how the situation is for them (Whitney and Trosten-Bloom, 2010). As with all things in life, if one looks for a problem, one will find a problem; but with AI, if a problem has been identified then an approach of focusing on what is working well and building subsequent solutions or processes is taken.

Traditional change management theory, as described by Hammond (2013), has a primary focus on what is wrong or broken. This means that because problems are being sought, they are found, which highlights and intensifies the problem, coupled with the belief that anything can be fixed and that there is a right answer or solution to the problem. AI, however, identifies the problem and then suggests looking at what works within the organisation, and focusing on the information gained from real experiences and history. People then know how to repeat their success (Hammond, 2013.) Cooperrider and Srivatsa (1987) outlined the differences between using an AI approach and a problem-solving process. The first step in a problem-solving process is the need to identify the problem; whereas AI is about appreciating and valuing the best of what is already happening. The second step in problem-solving analyses the causes, while AI moves directly into envisioning what the ideal state or process might be. This is followed by analysing possible solutions within problem-solving, but for AI the process is about entering into dialogue by

collective engagement in the creation of solutions or the ideal state. The final comparison reveals that problem-solving is about action planning or treatment compared to the AI process of innovation which focuses on doing more of what the people themselves have identified as working well; therefore, having a solution focused conclusion. (Cooperrider and Srivatsa, 1987)

Thus, problem-solving and AI are two very different models with two very different assumptions. Problem-solving assumes that something is broken, fragmented, not whole, and that it needs to be fixed; whereas the assumption with AI is that in every organisation there is something that works and by identifying and focusing on this strength, positive solutions can be built (Cooperrider & Srivatsa, 1987; Hammond, 2013). Furthermore, problem-solving has a tendency for people to feed off each other's negativity and creates a blame culture which was not the intention of this current research. Tom White, president of an American telephone company, said of AI "that it can get you much better results than seeking out and solving problems" (Cooperrider & Whitney, 2003).

Rationale for Using Appreciative Inquiry Methodology

To enable successful use of AI methodology, Cooperrider and Srivastva (1987) stated that the relationship between the researcher and the participant needs to be collaborative. This is a key factor considering the intent of AI is bringing people together to collaborate and rediscover positive and productive directions that had not been previously considered (Busche, 2007; Cooperrider & Srivastva, 1987). As a midwife, whose practice is based on the New Zealand Midwifery Model of working in partnership with women, these same skills are transferable to the role of midwife researcher working in collaboration with midwives participating in this study.

Carter (2006) and Whitney and Trosten-Bloom (2010) endorsed that AI is the study of what gives life to human systems when they function at their best, and this supported my intent for this study. I was clear from the beginning that the focus for this study needed to be from a positive perspective, which could be achieved through midwives relating what worked well for them, and why they had considered that the process was positive experience. People feel good about themselves when they are acknowledged or praised for their achievements, and this process would encourage

the midwives to tell their stories of what worked well for them at the interface of midwifery care handover. One of the guiding principles of qualitative research is that it tries to capture people's thoughts and feelings in their own words. Rees (2012) believed that the real world can only be understood through personal experiences and how that experience is interpreted. This interpretation of qualitative research endorses the principle of AI methodology – people telling their own reality, relating their own experiences, and identifying what they would like the future to be in their situation.

While a critique of AI is that it is all about positive aspects, it does in fact address the issues, challenges, and problems, and acknowledges conflict. However, it does so by shifting the focus and language from a negative viewpoint to a positive one, by asking what has worked in the past. AI is not about fault finding, harsh judgement, or culpability; rather, is in the discovery of what could be if changes were made (Preskill & Catsambas, 2006).

At this point, it is good to be reminded that the intent and purpose of this study, was to provide the opportunity for midwives to consider what they thought went well for them at the time of handover to another midwife. The interview provided a time for midwives to reflect on what had gone well, and to share their own beliefs and assumptions around the process they had used. The research provided an opportunity for midwives to share their reality with others, with the confidence that they would be heard, and their story would be told, thereby informing change for others. The AI methodology afforded the researcher the opportunity to conduct the study in a positive environment, with the participants being encouraged to recognise their role in the handover process and being acknowledged for their contribution by sharing their experiences and how this could help other midwives.

Gaining an Understanding of Appreciative Inquiry Methodology

AI is a methodology that has several explanations and steps that any researcher using this methodology needs to understand before applying this method to his/her research. AI is research process with an emphasis on the participants being involved as co-researchers, by asking them the answer to the research question that is being asked; in this instance, what do they think works well at the interface of midwifery care handover? Essentially, it is a collaborative inquiry process focused on

collecting and celebrating what works well, and having a shared vision that then lends itself to resolving any conflict that was the prime reason for the initiation of the research.

AI has eight assumptions, with the basis that something works well in every situation, and that by seeking out the positive and focusing on what is working well there will be a solution at the end of the process. These assumptions underpin the bases of AI methodology and the researcher needs to realise that these assumptions are the basis for the four key phases of the AI 4-D cycle; Discovery, Dream, Design, and Destiny. These four phases are the process for the study, for example the Discovery stage is when the researcher is "discovering" from the interviews and the data what is working well. The assumptions and the 4-D cycle are discussed in depth further in the chapter. In addition to the assumptions and 4-D cycle, the third consideration involves the eight AI principles which is also discussed in depth later in the chapter.

Appreciative Inquiry Assumptions

Assumptions or norms are a set of beliefs shared by a group of people which cause the people in that group to act or think in certain ways. While they are not usually visible, assumptions are a powerful force and if understood and appreciated, can explain a group's behaviour or perspective on a certain subject Whitney & Trosten-Bloom (2010). Hammond (2013) explained that AI has its own set of assumptions, which are:

1. In every society, or organization, or group, something works.
2. What we focus on becomes our reality.
3. Reality is created in the moment, and there are multiple realities.
4. The act of asking questions of an organization or group influences the group in some way.
5. People have more confidence and comfort to journey to the future (unknown) when they carry forward parts of the past (the known).
6. If we carry parts of the past forward, they should be what is best about the past.
7. It is important to value differences.
8. The language we use creates our reality.

(Hammond, 2013, pp. 20-21).

Understanding and appreciation of these assumptions is important to the researcher, otherwise he/she will remain in a problem-solving mode and will have difficulties when applying the AI methodology to the research. These AI assumptions may look reasonable but putting them into practice can sometimes be difficult. Take, for example, assumption eight regarding the language we use – all words have definitions and while there can be neutral words such as *the, at, on*, there are words that can also have emotional meanings such as *non-compliant* or *they just come and dump their woman.* The emotional meaning in the words then affects our thinking.

The researcher, therefore, needs to have an awareness of these assumptions so that he/she can then appreciate that the participants involved in the study will bring their own assumptions which will contribute to their view on what works well at the interface of midwifery care handover. For this study, I ensured that the questions asked at the interviews had been developed and organised with consideration of the AI assumptions. I was aware that my role in interviewing and asking the questions could influence the participant; hence it was important that the questions asked at each interview, and the way they were asked, were the same. The participants were asked about their experiences with handover of midwifery care, and what they considered had worked well for them. The participants were also invited to reflect whether they would like to see any changes and, if so, what they would be and why. In addition, I had to remember that the reality for each of the participants may not be the same; yet it was the reality for the participant that was being reviewed.

Development of the Appreciative Inquiry Process

Initially AI methodology was based on Cooperrider and Srivastva's (1987) set of four principles:

1. Appreciation – using grounded observation to identify the best of what is already there.

2. Collaboration – through vision and logic to identify ideals of what might be.

3. Provocative – collaborative dialogue and choice to achieve what should be.

4. Applicable – collective experimentation to discover what can be.

These principles were the original methodology used for the AI process and, later, these same principles became the foundation that built the 4-D cycle. The change came about when Whitney (2010) a researcher, who had worked with David Cooperrider and his original work, found that refining of the original four principles was needed. Hence, through collaboration with other researchers of the same mind set, the currently used 4-D model of AI, referred to as the AI 4-D cycle, was created.

The AI 4-D Cycle

The four phases of the AI 4-D cycle were used as a guide to inform the method for data collection for this study. The AI 4-D cycle is the process used and the four phases fitted well with the qualitative research being undertaken; and formed a good process to answer the research question: what works well at the interface of midwifery handover?

Discovery: This is the time to understand and identify "what is". To achieve this, one-on-one interviews were conducted with the midwives using affirmative questions focused on the topic, what works well at the interface of midwifery care handover? Interviews facilitated discovering and learning from their stories what was important and valuable to them, as midwives, at the point of handover.

Dream: This phase is for people to look at what they would like to see in the future in regard to their own professional lives and their colleagues. This phase is normally conducted in a group environment; however, for this study the group work was not possible. Instead, each of the midwives interviewed was given the opportunity to reflect and contribute to the Dream of what would be the optimal midwifery handover.

Design: The usual process for this phase is for a focus group coming together to work collaboratively on a plan to realise their Dream and move forward within their organisation. The participants, at interview, were all asked to consider what changes could be made, based on their own experiences, to make handover of midwifery care a positive experience for their colleagues. For this study, I analysed the data to look for common themes that the midwives themselves had contributed as possible propositions. These ideas were then written up as recommendations to support the notion of what an optimal midwifery handover would look like.

Destiny: This is the final phase of the AI 4-D cycle. It is about reviewing, communicating, and generating potential actions. I reviewed the data collected, and communicated and disseminated the findings to midwives through a variety of sources. The midwives that participated in the study were asked to review and reflect further on their typed transcripts. Following their review, they were offered the opportunity to contribute more information if they felt they had left anything out of the original interview. There was no additional information offered. It is hoped that the findings will be implemented for the benefit of all midwives involved in the handover of midwifery care.

The four phases of the AI 4-D cycle serve as the foundation on which change is built. They are the process that gets the participants to focus on the positive aspects which will then build the foundation for the proposed changes. However, in addition to these four phases, there needs to be a consideration of the eight principles that also underpin the methodology of AI and separates this methodology from other change processes and problem-solving approaches.

Five Principles Become Eight Principles of Appreciative Inquiry

The practice of AI is ~~also~~ informed by the principles of essential beliefs and values about human organising and change. The~~se~~ principles used for AI ~~are unique to AI and~~ have been developed from three streams of thoughts: social constructionism, image theory, and grounded research to inform (Hammond,2013).Whitney and Trosten-Bloom (2010) stated that these principles suggest human organising and change is a positive, socially interactive process of discovering and creating life affirming, guiding images of the future. Below is a summary of the eight principles and their definitions:

1. The Constructionist Principle – *Words create worlds.* Reality as we know it is subjective not objective, and is socially created using language and conversation. Words matter. They not only make a difference, they literally bring things to life, creating the world as we know it.

2. The Simultaneity Principle – *Inquiry creates change.* Inquiry is an intervention; the moment we ask a question we begin to create change.

3. The Poetic Principle – *We can choose what we study.* What we choose to study makes a difference. It describes and even creates the world we live in.

4. The Anticipatory Principle – *Images inspire action.* The more positive and hopeful the images of the future are, the more positive the present-day action will be.

5. The Positive Principle – *Positive questions lead to positive change.* The drive for change requires positive affect and bonding, and this is best generated through positive questions that amplify the positive.

6. The Wholeness Principle – *Wholeness brings out the best.* Wholeness brings out the best in people and by bringing all the stakeholders together creates creativity and builds collective capacity.

7. The Enactment Principle – *Acting "as if" is self-fulfilling.* To make change we must be the change we want to see. Positive change occurs when the process being used is a living model of the ideal future.

8. The Free-Choice Principle – *Free choice liberates power.* People perform better and are more committed when they have the freedom to choose how and what they contribute. (Whitney & Trosten-Bloom, 2010 p. 5)

The first five principles came from the early works of Srivastva and Cooperrider in the 1980s. However, after having experience of applying AI to large-scale organisations and community change efforts, Whitney and Trosten-Bloom (2010) developed and added three more principles, bringing the total principles up to eight. As summarised by Whitney and Trosten-Bloom, the eight principles of AI are about having conversations that matter. I went out to the midwives and asked them what has worked well at the interface of midwifery care handover and, by having these conversations with the people to whom the process most matters, was able to gain insight into the information that would inform a positive change for all midwives.

Summary

AI methodology is qualitative action research and has the underpinning assumption: that in everything there is good. To gain clarity around the AI methodology, the researcher needs to understand that there are these AI assumptions which need to be appreciated to separate the AI methodology from other problem-solving processes.

The 4-D cycle is the AI process used to get the participants to focus on the positive aspects and serves as the foundation on which change is built. The AI methodology is informed by eight principles that resulted from three streams of thought- social constructionism, image theory, and grounded research. These principles describe the difference between the AI process and other change management processes. They also act as a guide to the researcher when designing the research method and support the AI concept of having 'conversations that matter' (Whitney and Trosten-Bloom, 2010, p74.) For this study, I needed to go into the interviews with a focus of having the midwife tell her story as to what has worked well at the interface of midwifery care handover, and why it worked well. Ascertaining what really matters to that midwife at the time of handover will be the key to establishing a foundation to build on and gaining an understanding that I can eventually share with other midwives.

Method

The purpose of this, the second part of the chapter, is to describe the research method used, including the recruitment of midwives for the study and the processes undertaken for gathering and analysing the data. Ethical aspects, and any concerns or issues identified during the research process, will also be addressed. King and Horrocks (2014) claimed that the success of a qualitative interview study is not just how well the questions are asked or data are analysed, but also the decisions made when designing the study, as this can have a major impact on the outcomes. Therefore, the researcher needs to ensure the planning and design of the study is vigorous and able to capture the intent of the research question being asked. I also needed to fully understand my own position in regard to the research question and for this purpose my supervisors interviewed me and provided feedback regarding my responses. The principles and intentions of this study were to have a midwifery focus on a midwifery issue, approach the study from a positive angle, and have an opportunity to discover what is already working well.

Ethical Considerations

Research is not just about gathering data, there are ethical issues that must be considered when conducting a study. Ethics relates to the protection of the human rights for people participating in a study, and the researcher must show respect and protect the participants from harm and show fair treatment (Rees,2012). Ethics

approval was sought and gained through the Auckland University of Technology Ethics Committee (AUTEC) in 2015. The notification of ethics approval is included in the Appendix D. In addition to AUTEC approval, as a midwife and in a researcher role, I was bound by the professional Code of Conduct of the Midwifery Council (2010) and their principles of Accountability and Conduct were adhered to throughout the study.

Consent and approval was obtained from the New Zealand College of Midwives via the Midwifery Advisor who presented the request at a NZCOM Ethical Forum to advertise the study and ask for midwives to participate through NZCOM regional meetings. Posters inviting midwives to participate were designed and given to the chairpersons and administrators of the regional NZCOM committees for distribution and advertising of the intended study. Prior to the interviews, the participants completed a written consent form informing them of confidentiality, anonymity, and the right to withdraw from the study at any time. This was reaffirmed at the time of the actual interview (see Appendix D). The decision was made not to interview midwives that worked in the same District Health Board as myself, due to my position and responsibility as Midwife Leader, so there could be no biases for the study and no conflict of interest.

Recruitment of Participants

Criteria for selection to be included in this study were that the midwife was currently practicing in an environment where the care of the woman has been transferred to another midwife and that she had had more than one experience of handover. Exclusion criteria for this study were based on the focus of this study; that is, handover needed to be from a current clinical perspective and not a management one. Therefore, midwives that were not currently practising or were in management positions such as Director of Midwifery, midwifery leaders and educators, or any clinical midwifery management role were excluded. This would also prevent potential conflicts of interest or biases by having opinions or perspectives from a management view rather than an actual clinical interface experience.

Potential participants were given an email address to contact me directly for further information and register their interest in participating in the study. Following initial contact from the midwife, I then electronically sent a detailed information sheet for

participants that included the contact details of my supervisor for this research (Appendix B) and consent to participation in research form (Appendix C). The midwives that returned the consent forms became part of the study. Nine midwives initially registered their interest in being part of the study but only seven of these midwives completed the recruitment process and were subsequently involved. Follow up for the other two midwives was done but their circumstances had changed, and they withdrew from the study. In qualitative research, sampling and recruiting can occur at several stages through the study (King & Horrocks, 2014). The initial sample may be recruited and interviewed and then, based on initial data analysis, a further sample may be needed to address emerging issues. Following the collection and initial analysis of the data from the seven midwives, it was decided not to recruit any more midwives into the study. It was deemed that there were sufficient data from the seven midwives that had been interviewed and there was also recognition that the midwives were giving the same information whether they were the recipient of a handover or the donor.

The Participants

The midwives that met the criteria for selection and agreed to be part of this study were all New Zealand registered midwives, and five of the seven were New Zealand educated. The midwifery experience amongst this group of participants ranged from being employed in primary, secondary, or tertiary facilities; along with delivering a home birthing service. All midwives had experienced handover of care, either as giver or receiver, from one midwife to another midwife in their practice, whether it was as an employed or self-employed midwife.

The years of midwifery experience ranged from seven to 32 years; with a combined midwifery experience of over 125 years. All midwives were currently practicing, so consideration needed to be given around the timing of the interviews and where the interviews were done. For this reason, it was important to maintain anonymity for the participants and the area of employment, whether it be the region or the facility in which they worked. For the employed midwives, consideration was given to interviews needing to be away from their place of employment and outside their employment hours. For the self-employed participants, flexibility of place and time around their current workload and being prepared to defer the interview if the woman required it, were further considerations.

In addition to the anonymity of employment, each of the midwives has been given a pseudonym that is only known to the researcher.

Cultural Considerations

A component of the application to the AUTEC was ensuring consultation had taken place with Maori and other key stakeholders. This was done through the Bay of Plenty DHB's Maori Health Development Unit. There had been no concerns identified as the research was not specifically targeting Maori midwives; however, it was acknowledged there may be a midwife who identified as Maori offering to participate in the process. The agreement therefore was to respect, support, and honour the Treaty of Waitangi principles with all participants in the study to ensure their safety. As a New Zealand midwife, I work in a partnership as underpins midwifery practice in New Zealand, and this principle also applied to the research. A process had been put in place that a colleague from the Maori Health Development Unit at the Bay of Plenty DHB would be available if there were any cultural issues identified and I needed guidance. This process was not needed.

Consideration for Participants

There was no intent for this study to cause any discomfort or embarrassment for the participants; however, there could be times during an interview where recalling an incident may trigger a recall of an event that a participant has found to be distressing in the past. These situations could not be predicted, but the researcher and the participant agreed to acknowledge any discomfort or embarrassment and that, if needed, the interview would be stopped. The two parties would then decide whether to continue with the interview, come back together at another agreed time, or to withdraw from the study. The midwife would also be offered access to the NZCOM Employee Assistance Programme. At the end of each interview the researcher checked on the wellbeing of the participant and all seven participants confirmed that they had no concerns and were comfortable with the interview process.

Sampling Method

Cluett and Bluff (2006) explained that sampling is a key issue, as if it is inappropriate it will adversely influence the validity and reliability of a study. They further stated that sample sizing in qualitative studies tends to be small; the rationale being the strategies for data collection and analysis are time-consuming and there can be a considerable amount of data collected. Holloway and Wheeler (2010) noted that sample size in qualitative research is not an indicator of the importance of the study or the quality of the findings, and that generally qualitative samples consist of small numbers. Indeed, Rees (2012) stated that if the researcher is using a qualitative design, there is an expectation there will be small numbers as the purpose and focus of qualitative research is not numerical.

Convenience sampling is a non-probability sampling method as everyone does not have the same opportunity of being included in the study and there is no way of knowing whether this type of sampling represents the larger group. However, these methods are gaining popularity in that they are pragmatic in gaining quick and easy access to the sample (Rees, 2012). Self-selecting sampling is another example of convenience sampling and this was used in the study. The midwives volunteered to take part in the study by responding to a poster (Appendix E) that was distributed to regional chair persons for the NZCOM in the Midland Region. Rees (2012) suggested that convenience sampling does have some disadvantages, in that due to self-selection the participants may not necessarily be typical of the wider workforce they represent; however, the advantage of using this type of approach meant that participants were volunteering to be involved in a study in which they had an interest.

Consent

Following the initial email contact, a suitable time and place was arranged for the researcher and the midwife to meet. The consent form was discussed, as well as any further questions the midwife had regarding the study. Each participant signed the consent form, was offered a copy of the signed form to keep, and reassured that this form was to be kept in a locked cupboard as required by AUTEC. The midwives were informed that they had the right to withdraw from the study at any given time, and that they would see the transcripts from the interviews for their approval. The participants were aware that the interviews would be transcribed by a third party and

that this person had signed a confidentiality agreement (Appendix F) with the researcher, also that there was no vested interest in the information by the typist. The transcripts were electronically sent to each of the midwives as a WORD document. At this point participants could add or delete any of the data prior to the analysis process commencing. One midwife added to her transcript and another changed some wording, but this did not alter the meaning of the content. Contact was made with all seven participants again confirming that they were consenting to the data being used and that that there were no more amendments or changes they wanted made. All seven confirmed the use of the data for the study.

Anonymity and Confidentiality

To maintain anonymity for the midwives involved in the study, at the time of the interview the midwives were only identified numerically (Midwife 1, Midwife 2 etc.). The transcripts were similarly labelled. I was the only person who knew the identity of each of the midwives; this information was not shared with my research supervisors. All the data relating to the transcripts were electronically protected by having all the files password protected. Again, only I had access to this information. The transcripts were loaded onto a data memory stick and given to the researcher by the typist. The typist kept no record of the transcripts; this was confirmed by the researcher and the typist after the transcribing. The participants were fully informed of the role of my supervisors in this research and I reassured them that their anonymity would be maintained even with the supervisors. The places of work were not identified. Further, I double checked to ensure that if the interviewee had referred to a person or a place that was identifiable, that this information was removed from the draft transcript, which was only seen by me. The midwives themselves, at the time of the interview, were conscious of the need to maintain anonymity and used references such as "another midwife, my colleague, or obstetrician" when they were talking about a situation. They also referred to the birthing and maternity facilities as being "primary, secondary, or tertiary". Midwives in general had awareness that I was undertaking this study, as it had been advertised through the regional NZCOM meetings, but at no point in time was there any discussion around who had participated in the study. Confidentiality for the participants has been maintained. At the time of writing up the Research Findings, for ease of reading, I then gave each of the midwives a pseudonym and instead of

being Midwife 1, or Midwife 2, they became Amy, or Beth, still with no-one else other than myself knowing the true identity of the midwives participating in the study.

Interviews

Rees (2012) suggested that a major consideration in carrying out an interview is the location and the environment in which the interview takes place. The participant should feel relaxed and comfortable with as few disturbances or distractions as possible. This is supported by King and Horrocks (2014) who stated that the physical space in which an interview is located can have a strong influence on the information shared by participants; with comfort, privacy, and quiet being the three important physical aspects. With this knowledge, the interviews were setup and arranged by the midwives, and I met them at the appointed time and place. Participants were interviewed in their clinics, their homes, private area at work, and one midwife wanted to be met at a café close to her home and away from work where we could have some privacy. All the midwives had my contact number if they needed to make contact outside of the interview meeting. None of the midwives used the contact number outside the interview meeting. To put the midwives at ease, the interviews were all opened with me talking about my research and my role as a midwife. This was to establish a relationship and give the participant being interviewed an opportunity to withdraw from the study should she wish to do so. It is often commented that midwives are good story tellers and these participants were excellent examples. A professional relationship was maintained throughout the process including any follow ups that were needed.

The intention was to have the interviews lasting 30 minutes but after the first two interviews I quickly discovered that midwives like to tell their story and flexibility was necessary to allow the midwives being interviewed, the time that they needed to recollect and discuss their practice. The average time for an interview was more realistically 60-90 minutes, so the extra time was then scheduled into the timeframe for the subsequent interviews. The interviews concluded by mutual agreement, generally when the conversation was starting to diverge, and I felt all areas had been covered in the interview. The midwives that were interviewed all stayed focused on the chosen topic of what works well at the interface of midwifery care handover, but

they were also able to reflect that there were times when things had not gone as well as they could have.

King and Horrocks (2014) stated that in most cases, with qualitative research, it is preferable to have a full record of each interview whether that be audio or video recording. The interviews were audio recorded and, prior to the interview being commenced, a test with the equipment was done to assure me that the equipment was functioning, and put the midwife at ease and make her comfortable with the recording process. The small compact audio recorder was placed close enough to both parties without being intrusive.

Concerns of the Researcher

A concern I had was that my current role as a midwifery leader for a DHB would be a barrier, and midwives would not be as open and honest about their experiences or would not want to share their personal experiences. These concerns proved to be unfounded, but they also validated my decision not to interview midwives in my own DHB area to prevent any bias for the study. I had to remember to listen and not interfere in the process of research, participants' reflections, and sharing of their experiences.

Data Collection

Interviews are the main means of collecting data for qualitative research (Cluett & Bluff, 2006) and a key requirement of qualitative interviewing is flexibility (King & Horrocks, 2014). Rees (2012) stated that interviews have a great deal to offer midwifery research as the nature of data collected tends to be much deeper and richer compared to the use of a questionnaire. Rees also added that interviews utilise the midwife's professional skill of sensitively collecting information through a conversational medium. Other advantages of interviews, as outlined by Rees (2012), is that participants can feel more in control in semi-structured and unstructured interviews and therefore feel more valued. The presence of an interviewer also reduces misunderstandings and interviews are suitable for a wide range of people who would otherwise have little time or even interest to complete a questionnaire. The disadvantages in using interviews is that participants may provide answers that do not reflect their opinions but are perceived to be more socially acceptable, or that

they may not be used to expressing feelings or emotions openly or reflecting on events. The other disadvantage is that participants can be influenced by the interviewer's status, characteristics, or behaviour. For the interviewer, the main disadvantages are that he/she needs to have the skills and experience of interviewing and that data analysis can be much more time consuming (Rees, 2012).

On reflection of the advantages and disadvantages, the advantages for this study far outweighed the disadvantages; that is not to say they were not carefully considered. On the contrary, each example given as a disadvantage was addressed by the researcher. The interviews focused on the actual experience of the midwife being involved in the handover – it was not based on hearsay and if reference was made to another midwife's experience then the researcher would ask if the midwife had experienced that herself. Being aware that I was known as a midwifery leader employed by a DHB, I put an emphasis on being a midwife doing research; I did not want the midwives that were being interviewed to think that this study was coming from a manager's perspective. The intention of this study was to improve processes for midwives and keep women safe at the time of handover of midwifery care.

Reviewing King and Horrocks' (2014) *Interviews in Qualitative Research*, and Rees' (2012) *Introduction to Research for Midwives*, gave me the opportunity to gain insight around the art of qualitative interviewing. These texts, along with the support of my supervisors, gave me the confidence to develop the interviews. I appreciated the importance and value of getting the questions right and, at the same time, acknowledging I was not going to get it right first time. The researcher must ensure he/she has carefully considered all the factors prior to conducting the interview as this is the start of the process of data collection.

The following is the initial set of questions which was put together and is presented with a rationale of why they were going to be asked.

- I would like you to tell me about your clinical midwifery experience to date. *Rationale: This would be their opportunity to talk about their midwifery career and open the conversation.*
- Are you able to tell me about your understanding of the maternity documents that we know as Section 88 and the Referral Guidelines? *Rationale: These documents are part of the process of handing over.*

- Tell me about your understanding of the generic Access Agreement in Section 88 that all LMCs must have to bring a woman into a facility? *Rationale: The access agreement has a clause regarding clinical competencies where the midwife must inform the facility if she has the appropriate competencies to provide the care for the woman for the listed procedures. For example, induction or augmentation of labour or management of women requiring epidural. If the midwife does not have these clinical competencies, then there could be a handover of midwifery care and the core midwives need to have an awareness of this clause.*

- Can you tell me what is the general consensus in your work environment around these documents and how these documents are used or referred to? *Rationale: Gain an understanding of whether there is an awareness of the documents.*

- I would like you to tell me about your understanding of the Midwife's Scope of Practice and how this supports your own clinical practice setting? *Rationale: Gain an understanding of the level of support the midwives handing over receive.*

- Given there are times when a woman's pregnancy or labour and delivery can get beyond the area of practice of a midwife and the care needs to be handed over to another midwife, can you tell me about your experience involving handover of midwifery care?

- What do you think worked well during this process?

- Why do you think it made a difference?

- Was the woman considered in the process, if so how and what would the considerations have been? *Rationale: Handovers require a three-way discussion between the midwives and the woman.*

- If you could change anything at all for the process of handing over, what would you like to change and why? *Rationale: Opportunity to look at further improvements in their own work environment.*

I presented these questions to my supervisors and was then asked, "What was it I was trying to achieve?" I quickly realised that these questions were not going to answer my research question of what works well at the interface of midwifery care handover. To continue with this line of inquiry would in fact take the study in a completely different direction of where it was intended. The questions were then revisited, this time keeping a focus on the research question. Referring to the AI 4-

D cycle I considered how the midwives could respond to the interview questions to answer the research question. The questions were designed to be unstructured so that the midwife being interviewed could elaborate on what was important or relevant to them and also act as a trigger to further develop discussion if necessary. King and Horrocks (2010) defined characteristics of the general qualitative interview as being flexible and open ended with a tendency to focus on people's actual experiences more than general beliefs and opinions.

The revised set of interview questions was as follows:

- *Background/demographic question*
  Tell me about your midwifery background and your midwifery journey to date.

- *Experience of handover*
  This study is about midwifery care handover, could you tell me what your experience is and how it has been for you?

- *Opinion*
  Given that this study is about what works well at the interface of midwifery care handover, can you tell me about a time when handover worked well?

- *Feelings*
  How did you feel at the time and what were your main considerations around the handover?

- *Dreaming*
  If you could change anything at all for the process of midwifery care handover, what would it be and why?

Following further discussion, my supervisors suggested that I pilot the questions and test whether they would answer the research question. These interview questions were then piloted on two midwives who were not going to be part of the study. Taking the data from this pilot I was then able to analyse what information I had collected and felt confident that these questions would be able to answer the research question.

Planning for the interviews was more than just what questions would be asked; it was about me being flexible to meet the needs of the midwife being interviewed, including time and place of interview. Building in factors such as allowing time to

travel the distance between towns and then the different places that had been agreed upon, not knowing the area meant using devices such as Global Positioning System (GPS) and Google maps on the phone. The interviews were carried out over a week, with me going and staying in the area and travelling to the interviews at the pre-arranged times. This enabled some of the interviews to be completed outside of work hours and clinic times and allowed for the midwives to be relaxed and not concerned that they needed to rush off and provide care for the woman. There was always the agreement that if a woman needed the midwife we would reschedule the interview. All interviews were audio taped; however, I also took observation notes or field notes, using a bullet point method to ensure that all the intended interview questions had been asked and were answered. There was no need to replay the audio tape back to check. The written notes served as a reminder if any clarifications were needed and also gave an opportunity for the midwife to either expand or offer further explanation on any point, if she wished at the time of the interview.

Transcripts

The rationale to use a typist was the time factor. As the researcher, I was aware that following the interviews there could be a large amount of data collected. This was proven correct when pages and pages of data were returned from the transcriptionist. It is estimated that one hour of interview can take between four and eight hours to transcribe. The midwives were aware that the interviews would be transcribed by a third party and they all consented to this process. I checked the transcripts to ensure there were no identifying factors related to either the workplace or the midwives. Any references were removed from the transcripts.

Reflexivity

As a midwife, undertaking research into an aspect of midwifery care, I needed to be aware that I might influence the data collection, interpretation, and results due to my innate bias or experiences. It was important, therefore, that I had an awareness of my own behaviour and responses during data collection. I was aware that for the research process to have validity and rigour I needed to maintain an open mind throughout data collection and analysis by ensuring that I was working with the responses I had been given, not what I thought had been said or based on what I

wanted it to be. This took self-discipline and a constant referral back to the audio tapes and transcripts.

Reliability

Reliability relates to the method of data collection and data analysis used, and refers to the accuracy and consistency of the findings produced by such methods (Rees, 2012). The tool used for this qualitative study was face to face interviews with midwives that had experience of handover of midwifery care, whether they were the recipient or the provider of handover. To ensure the trustworthiness of data collection, all answers were recorded, and the transcripts were checked for accuracy and authenticity against recorded information. The same questions were used for all the midwives (Appendix G). The method of thematic data analysis ensured that the data collected and transcribed were read, coded, and collated, and further cross checked to ensure the collected data answered the research question and related to the literature. Additional rigour was achieved through the process of my supervisors reading data extracts and providing feedback on collation and coding.

Transferability

This study was about midwives handing over information and care responsibilities to each other, and the focus was on midwives in one region of New Zealand. However, in the healthcare setting, midwives can be in the position of handing over to other health professionals, such as doctors, physiotherapists, dieticians, and social workers. By identifying factors that contribute to positive and safe transitions of care between midwives, there is an opportunity to consider the applicability of these factors for other health professionals in their handover situations. Qualitative studies are not normally transferable, but they do have the opportunity to offer insight that maybe helpful for others providing the same service.

Rigour

This study has been conducted as a logical and systematic research process that has been overseen by two supervisors. The methodology for this study has been described and reviewed, and was appropriate for this study. While it should be acknowledged that there is difficulty in validating the applicability of a study such

as this, the academic supervision process required clear explanations from the student researcher outlining the methods, and the rationale for each decision made was reviewed by the supervisors throughout the research process which brings rigour to the qualitative research methods used. The continual checking of the question and the methodology, with the actual research method and processes used also added rigour and provided congruence between these different parts of the research. The midwives that participated in this study owned the information that they shared with the researcher and could review and correct any data that did not represent their experience or knowledge. As noted by Cluett and Bluff (2006), qualitative researchers must often defend their methodological rigour as their research is often viewed as non-traditional or non-scientific. For that reason, rigour needs to be overt and systemically considered and reviewed by supervisors from the outset of the study. This was the case in this research as illustrated by the earlier example in the Data Collection section, when the process that was used about ensuring the questions asked of the participants was congruent with the research methodology and the research question itself, resulted in a complete change of the questions to be asked at interview.

Qualitative Data Analysis

Qualitative data analysis is when the researcher analyses the information that has been collected and looks to understanding what the data is saying through establishing themes and what they reveal about the study. Qualitative data analysis is described by Woods (2011) as being about identifying, coding, and categorising themes within the collected data. Appreciative Inquiry, being the methodology used for this study, refers to data analysis as interpretation of the data as it needs to be done in a totally different way to other action research. As stated by Bushe, (1995) AI really challenges those doing the analysis to leave their preconceptions behind and approach the data with 'the eyes of a child'. The process for AI methodology is often managed in a group setting where change management is the focus. In keeping with the intent of AI, the focus is on affirmative topics. The four characteristics shared, regardless of the topic, are that they are positive, stimulate learning, are desirable, and stimulate conversations about desired futures. The objective is then to have three to five compelling, inspirational topics that will be the focus for in-depth inquiry, learning, and transformation (Whitney & Trosten-Bloom, 2010).

The AI process portrayed by Whitney and Trosten-Bloom (2010) is transferable into research methodology that links with thematic analysis as described by Braun and Clarke (2006). The aim of discussion in a group setting is to identify the themes. The group then discuss the patterns and themes that have emerged. If the final topics are unclear, clustering of proposed topics are grouped together to identify subtle similarities and differences, keeping the focus on the original topics rather than meaningless cluster of words. If there is still no clear selection of three to five topics then the clusters must be narrowed down further, usually by facilitating a vote from the participants. Eventually the three to five topics are agreed upon and selected. The final step being that participants in small groups select a single topic name that best describes the spirit, intent, and essence of the original interviews.

With my understanding of what has been described as the process for AI, thematic analysis was seen to be an appropriate method of data analysis for this research. Braun and Clarke (2006) stated that thematic analysis is a qualitative analytic approach that works well when some researchers are less qualitatively experienced. Their clear guidance as to how to carry out thematic analysis supported the decision to use their six phases of thematic analysis as described below:

1. Familiarising yourself with the data: *Transcribing data, reading and rereading the data, noting down initial ideas.*

2. Generating initial codes: *Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.*

3. Searching for themes*: Collating codes into potential themes, gathering all the data relevant to each potential theme.*

4. Reviewing themes*: Checking the themes work in relation to the code extracts (Level 1) and the entire data set (Level 2), generating a thematic "map" of the analysis.*

5. Defining and naming themes*: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.*

6. Producing the report: *The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating*

back of the analysis to the research question and literature, producing a scholarly report of the analysis (Braun & Clarke, 2006).

Phase One: Familiarising Yourself with the Data

The audio tapes were listened to repeatedly, firstly immediately after each interview, as there were distances to be travelled between interviews, and then again when I was reviewing notes that had been taken during the interview. The interviews were professionally transcribed but I wanted to capture the essence of the interviews in the hand-written notes as well, while the recollection of the interview was still vivid. The transcribed data were read at the same time as listening to the audio tape to confirm that nothing had been lost in translation or transcription. By reviewing the hand-written notes and listening to the audio taped interviews it was noted that some broad themes were starting to emerge. For example, all the midwives commented on the need for a better understanding of each other's roles. The midwife coming in with the woman for the handover of care would make comments about the midwives in the hospital not really understanding what it was like for the midwife in the community. The core midwife would make a comment about the midwife transferring not realising they had three handovers already and there are no staff available, and no time to find staff.

Phase Two: Generating Initial Codes

Used with the guidance of supervisors, the initial method was to electronically colour code a broad theme within the content of each of the interviews. For example, "Factors that impact on handover" were all coloured red. Thus, each of the transcripts would have a series of colours highlighted through the text for ease of recognition of that broad theme. It also became apparent that there was a tendency to put too much information under each of the headings and that there would need to be more fine tuning around the interpretation of the data. It was very easy to highlight large portions of the text and conclude that it was all related to the one code. This required careful consideration of what the participant was saying and what was the important message in the text that needed to be highlighted and put into context of what the theme was relating to.

Another challenge was that some of the data could go under three different code headings. This issue was resolved by having a miscellaneous category that was then

reviewed after the initial work was completed. Data that could go under three different categories were placed under the three possibilities knowing that there was still another defining process prior to the final decision. There were 15 different code categories at this stage, including the miscellaneous one, with very large amounts of data under each of the headings. It was realised at this point that there needed to be some review of the process that was being used and that I needed to go back to the research question and ask how does this piece of data or theme answer what works well at the interface of midwifery care handover. The data in each of the 15 code categories then needed to be reviewed and themes identified.

Phase Three: Searching for Themes

Braun and Clarke (2006) explained that a theme captures something important about the data in relation to the research question. In qualitative research there are no hard and fast rules but ideally there would be several times that the theme appeared across the data set (Braun & Clarke, 2006). The next step in the analysis process was to take the data from each of the colours and to look at the information that had been categorised and further analyse this data by looking for themes and where they had been repeated. For example, when the midwives referred to communication, I questioned how was communication discussed and what were the common threads that the midwives had raised? Good communication was a common thread, but then what did they consider to be good communication? What were the key words used when the midwives spoke about communication? Searching for themes was very time consuming but also very valuable as often another important piece of information would be discovered that could then help answer the research question.

Phase Four: Reviewing Themes

A thematic map approach was employed by taking coloured post-it notes, large sheets of paper, using key words and categorising them. It was easy to put the midwife's number with the contents on the post-it note, as the midwives had been numbered one to seven. That way there was a reference back to the interview to confirm the statement and it also showed which midwives were contributing to which category. By using this method, key words were identified which could then be grouped together to identify the key themes. These were based on the key words that had been used for the literature search at the beginning of the study. Key words included: interface, midwifery care, and handovers. Next, using the suggestion from

Cluett and Bluff (2006), a thesaurus, being a list of words in groups of synonyms and related concepts, was used. This expanded the list to include, interactions, communications, consultation, relationships. Taking the key words, themes started to emerge and gave some clarity to the data that had been collected. This then reduced the themes down to eight with the realisation that further work was needed to look at the data and refine the specifics of each theme. At this stage, the eight themes identified were:

- Diversity of midwives
- Transfer/Philosophy
- Handover process
- Handover information
- What works well for handover
- Impact on LMC rural and urban midwives
- Impact for core midwives
- Midwife's expectations

These eight themes were then reviewed further looking for similarities which occurred regardless of the midwife's employment status or area of work. It became apparent that these eight themes could be further reduced to four when another review of the data was completed, and consideration was given to the data that sat behind the key words. This was completed again using large sheets of paper and post- it notes.

The four themes:
- Diversity of Midwives – relationships, midwifery care provided, collegial support, where they work, how they work, philosophy, rural practice, urban practice.
- Impact on LMC midwives practice around handover of midwifery care – historical views of handovers, acknowledgement of rural practice.
- Impact of handover of midwifery care for core midwives – lack of staff, processes used for handover, number of handovers being received.
- What works well for handover – communication, the transfer process, current practices in the hospitals, consultations, interactions, relationships.

Phase Five: Defining and Naming the Final Themes

I revisited each of the four themes and concluded that there could be further interlinking and regrouping of the data to keep the focus on the research question: what works well at the interface of midwifery care handover? The conclusion was that there was the opportunity to strengthen the argument by taking the impact of handover of midwifery care on midwives as one theme instead of two, and the realisation that the data collected needed to be further analysed as the themes were getting too broad and diverse, instead of focusing on what the data was really saying. The outcome was to have three main themes for the research findings that the data could sit under with a sense of priority.

1. **Profiling the midwives' employment.**

Diversity of midwives was about setting the scene for the research, demonstrating the versatility of the participating midwives, and the variety of practice in the scope of midwifery practice. This highlighted that seven midwives who participated in this study were typical of the New Zealand workforce; their practice ranged from primary care to tertiary care, and they were either LMC or core midwives. The decision was then made to have the first theme discuss the midwives' work environment and was named: profiling the midwives' employment status.

2. **The impact of relationships at the interface of midwifery care handover.**
Looking closely at the data that was under the impact of handover of midwifery care for the LMC midwives and the core midwives, it became apparent that this data reflected more on the relationships and how those relationships impact on the interface of midwifery care handover. Thus, rather than have two separate themes it was apparent that there could be a comparison of the data under the one theme.

3. **Looking at the processes and what works at the interface of midwifery care handover.**
The midwives clearly identified what they thought worked well at the interface of midwifery care handover and the themes that came through spoke volumes from all the midwives; for example, the importance of communication and the use of a tool to support the communication. I then decided the most appropriate

way to demonstrate what the midwives were saying was to place this data under a theme discussing processes.

Summary

The second part of the chapter has outlined and discussed the methods used for this study. Ethical and cultural considerations have been discussed along with the process used for recruitment and protection of the participants. The data collection and analysing process used in this research have been described. The decision to use Braun and Clarke's (2006) six phases of thematic analysis supported me as a novice researcher who was not experienced with analysing qualitative data. The process described by Braun and Clarke resulted in three final themes used for the research findings: Profiling the midwives' employment, the impact of relationships at the interface of midwifery care handover, and looking at the processes and what works at the interface of midwifery care handover. This process complimented AI and meant that the data was analysed into a way which best answered the research question what works well at the interface of midwifery care handover.

Chapter Four: Research Findings

This chapter will set the scene and demonstrate that in New Zealand midwives work in a variety of settings. New Zealand midwives may "practise in any setting including home, the community, hospitals, or other maternity services. In all settings, the midwife remains responsible and accountable for the care she provides" (Midwifery Council, 2004). Grigg and Tracy (2013) provide an explicit description of how midwives work in the New Zealand maternity service; midwives can choose to work part or full time in the core role, which is shift based with set hours of work in hospital centres, may involve complex care, and has limited continuity of care; or as LMCs in the community, which is on call with variable hours, community centred, and involves full continuity of care. Some midwives choose to work part-time in both roles at the same time. The midwives involved in this small study were self-selecting; yet they represented a cross section of the New Zealand midwifery community and all have experienced midwifery care handover. These midwives were well placed to answer the research question: what works well at the interface of midwifery care handover?

Profiling the Midwives' Employment

This initial chapter is an introduction to illustrate the work environment of the midwives who participated in the study. The midwives were self-selecting in their participation in the study, with the only pre-requisite to participate being that they had experienced midwifery care handover more than once. Each of the midwives explained her workplace setting, and then described what was important to her in terms of the process of midwifery care handover. The model of maternity care in New Zealand means that midwives can move between being employed to self-employed and vice versa, or a combination of the two. The midwives in the study represented various roles as demonstrated in Table 1 below

Table 1: Employment status of the midwives at the time of the interview

Midwife	Current		Prior Experience		Community Practice		
	DHB 2nd/Tertiary	Primary Birthing Unit	DHB- 2nd/Tertiary	LMC Experience	Rural LMC	Semi-Rural LMC	Urban LMC
Amy		yes			yes		
Beth	yes			yes			
Cindy	yes			yes			
Debra			yes			yes	
Emily			yes				yes
Gina					yes		
Kate	yes						

Three of the seven midwives interviewed were employed at a DHB facility, with a fourth midwife holding a contract to provide services to a rural primary care unit. Of the seven midwives interviewed, only one had not had experience as a LMC. Two of the LMCs had not been employed in a secondary or tertiary maternity care unit. Two LMCs had rural practices, one semi-rural, and one LMC had an urban practice. A summary of the type of work midwives in the do can be found in Table 2.

Table 2: Type of work the midwives in the study do

Midwife	Homebirth/Primary	Secondary/Tertiary	Other Midwifery Appointments
Amy	yes		
Beth	yes	yes	yes
Cindy	yes	yes	
Debra	yes	yes	yes
Emily	yes	yes	yes
Gina	yes		
Kate		yes	yes

Six of the seven midwives had experience providing midwifery care in a primary care unit or homebirth. Five of the seven midwives had secondary or tertiary experience; with four of the midwives having experience in other areas of midwifery practice and away from the provision of care normally associated with midwives during the antenatal, labour/birth, and postnatal periods.

Amy, a rural midwife, gave a good example of a midwife who has a case load - providing a LMC service to the women in a rural setting but, at the same time, has a contract to provide primary care at the local primary birth facility, offering midwifery cover. This is not an uncommon practice and is of value in the rural settings when midwifery cover is limited. On one hand she is self-employed, but then on the other she is employed:

> *We have two hats - one is our independent LMC collective hat, which is the same as any other LMC practice. Our other hat is that we provide midwifery cover for the primary birth facility.* (Amy)

There are many midwives who choose to be employed and self-employed at the same time. The core midwife may choose to have a small case load, be a backup midwife for home births, or cover for a LMC midwife who has a weekend off. The self-employed midwife may have a casual contract with the facility and will do shifts when her caseload permits. The midwifery profession and uniqueness of the New Zealand maternity model of care is one that allows the ebb and flow of midwives between being employed and self-employed, which benefits the local needs and gives lifestyle choices to the midwives.

Summary

The experience and variation of midwifery roles, identified during each interview, demonstrated the diversity and flexibility of the midwives involved in the study. The criteria for this study was not based on what their roles were or had been, only that they had experienced more than one occasion of midwifery care handover. The range of settings, demonstrated in this research, validates the diversity of midwives' work environments and that as a profession; midwives have come to accept this as being the norm. From these seven interviews, it was also clear that for some individual midwives the diversity and flexibility meant working in a variety of settings, which calls for a different skill set for each setting. Having established that the research sample represents practice in a range of settings it became apparent that the process of midwifery care handover is not limited to, or restricted by, the work environment, and that midwifery care handover occurs across the midwifery practice spectrum.

Chapter Five: The Impact of Relationships at the Interface of Midwifery Care Handover

The purpose of this chapter is to present processes, attitudes, and values which the midwives felt were important to them at the interface of midwifery care handover. All the midwives interviewed built a picture of what worked well for them and what they thought were some of the contributing factors that determined the success for them at the time of the handover interface. The main theme identified from data analysis was the overriding importance of relationships. The midwives conveyed how these relationships were built, and how these associations affected the interface at the time of the midwifery handover of care. McAra-Couper, Gilkinson, Crowther, Hunter, Hotchin and Gunn, (2014) found that the midwives in their study articulated that it was the relationships that sustained them in practice; not only the relationships with the women, and their practice partners, but with the midwifery community at large. The themes discussed in this chapter are about the professional relationships and communication, and what influence they have on the interface of midwifery care handover.

Midwifery Relationships

The midwives spoke about the importance of establishing midwifery relationships. Gina (LMC), when reflecting on her experience of what worked well at the interface of midwifery care handover, described the value of having formed midwifery relationships:

> *Sometimes your established relationships with people have an impact as well. I know I get so much more respect now and it is not that I felt disrespected when I started in practice, but I get so much more respect now because I have been practising for a while. If I ring and say I have got a problem, they know to take it seriously and not just like, hang on a minute. It is those midwifery relationships [that are important] because the doctors change all the time. For example, recently I had a situation that was deteriorating, and I didn't know the doctor, he didn't accept my assessment and he did his own vaginal examination, it was the same as mine. All the time I am getting frustrated with the delay, and the coordinator ended up pretty much intervening and saying we need to go to theatre now. And we did. I was really worried about that baby, she ended up fine, but it could have been very different.* (Gina)

Gina identified the importance of the relationship between the core and LMC midwives at the interface of handover. She acknowledged that the doctors change and leave the unit; whereas the midwives are established in their roles and ongoing relationships are important. For Gina, in this example, relationship then makes a big difference when she is transferring in with a woman. The midwife coordinator knew Gina well and acknowledged and supported her decision making for transferring into the unit. Whereas the doctor who did not know Gina, wanted to make his own assessment of the situation and this delay added more stress to the situation for Gina. However, because the coordinator and Gina had an established relationship, the coordinator initiated the move to get the woman to theatre and overrode any further delays. Gina conceded that in this case they did have a good outcome. However, she identified that there could have been a very different outcome for that baby without the intervention of the coordinator midwife. The two midwives managed a sound working relationship at the time of handover, which Gina valued. The challenge for Gina was not having the same working relationship with the doctor, which she found stressful.

Debra (LMC) also acknowledged that it was having those relationships, and being conscious of her own attitude with her colleagues, that influenced the handover of care:

> *It varies, and I put that down to my years of experience and that accounts for a lot, so I have forged those relationships quite a lot. I go in planning on not having a problem. If I go in expecting to have a fight, I am more than likely to have a fight. Obviously, that is where attitude is important when you are staying on as support. If you had friction going on in that room, the woman is going to notice it straight away. And it should be about them, birthing, it is not about me. It is about them. If the woman is being cared for by the staff let them birth, check the baby and all that, but if they want me to do something, ask and that is fine. We can work together because we can learn from each other.* (Debra)

Debra acknowledged that her years of experience helped to ensure a smooth handover process. She has forged relationships over a long period of time and this shows a positive attitude at the interface of handover. Debra also wants the relationship with the staff to be good so that when she stays on as support, the woman can then go on and birth with confidence that the LMC and the staff midwife are working together to support her. Debra is also comfortable when her midwife

colleague asks her to do something, and values a shared learning opportunity within this exchange and shared care.

Emily (LMC) describes her experience of when she transfers a birthing woman from a primary facility into a secondary facility for consultation with the obstetrician:

> *Frequently it is a good experience with handover. When I arrive, and the room is actually prepared for us, a room prepared for us, means the lights are on, there is an incontinence sheet on the bed, there is a jug of water on the side board. The basics are there, and it is not like we automatically expect any of this, so when it is I find that is just the first step in the welcome. One it shows that the message has been received that we are on our way and that they are expecting us and that they are being proactive in preparing the room - showing that they are proactive to welcome us basically. Then the next thing is to have a core midwife come in and assist with the basics like helping to put the Cardiotocography (CTG) on, asking if there is anything they can do to help like take a set of observations and then to let us know that the registrar is aware, and could they do anything else to help us.* (Emily)

It is the little things that count for Emily as to whether the transfer in has been well received. This demonstrates a sense that the relationship between the core midwife and the LMC midwife is supportive and positive. As Emily stated she does not expect the room to be prepared but it certainly makes both the midwife and the woman feel welcomed into the facility. The relationship with the staff midwife makes a big difference and Emily feels supported when the offer of help is made.

Unfortunately, it is not always like that and there have been times when Emily has found the professional relationship is missing. She feels this can then impact upon the woman. Emily described the situation she found herself in when she had transferred in from a primary birthing unit:

> *I expected that she will acknowledge the journey we have already been on and I find that often it is missing. For example, the other day the midwife was 100% committed on trying to get the woman to birth naturally and we had already been doing that for nearly 24 hours.* (Emily)

The lack of a professional relationship in this situation meant that there had been no acknowledgement of what Emily and the woman had been trying to achieve. What Emily wanted, at the time, was a consultation with an obstetrician regarding the

ongoing management of the woman's labour. Instead she felt that the midwife she was handing over to ignored the journey that she and the woman had already been on, which left her with a sense that her professional judgement was not being respected or acknowledged. Emily felt that this potentially gave a different message to the woman and, rather than working with her she felt that the midwife was working against her. Midwifery relationships and established relationships in which the midwife is valued and acknowledged are important in facilitating the process of handover.

Amy, a rural LMC midwife, covers the primary birthing unit in her area, as well as having a LMC caseload. This means that if any woman under Amy's care requires an intervention, such as induction of labour or vaginal birth after caesarean section, the woman will require a midwifery handover of care, as due to her commitment to the primary birthing unit and her rural caseload Amy is not able to be away from the rural area she is covering for any length of time. Interventions cannot be done at the local primary birthing centre. Amy transfers the care of the women requiring these interventions to another midwife who will provide the care at a facility where there is obstetric cover. Amy talked about the importance of establishing relationships and how she has done this with midwives that she has never met face to face:

> *Because I cannot look after a woman that needs to deliver in a secondary care unit, I actually organise a LMC midwife who works in that area to provide the labour and birth care until the woman transfers back postnatally to me. As the person handing over, if I am handing over to another LMC and organise one, I like the midwife taking over from me to have a similar midwifery philosophy to me, because the women choose me, for my philosophy. So, I like to be able to pass them on to a midwife that has a similar way of looking at things because I think that is as fair as I can get for the women. I use two midwives. Funnily enough neither of which I have actually met. I have had phone conversations with them, and I have had feedback from the women really good stuff. So, I must meet them one day as I haven't actually met them.* (Amy)

Amy described the relationship forged with two LMC midwives who take-over a woman when transfer to the hospital with obstetric services is required. Amy emphasised the importance of colleagues having a similar philosophy and she received really good feedback from women about these two midwives. This handover arrangement works well for Amy as she trusts these midwives to care for

these women in the same way she would have, and is then able to provide the postnatal care when the women are transferred back to her. The transfer for the women is an easy and smooth pathway as all the midwives involved in the handover have similar philosophies and the women are their focus. Furthermore, the fact that they have never met face to face suggests that the midwives involved in the arrangement all have respect for one another. Hunter et al. (2016) concluded that for sustainability midwives need to work in partnership with their colleagues and women in a way that enhances mutual respect and appreciation of each other's roles.

While the midwives acknowledged the importance of having that professional relationship with their colleagues, barriers that hindered the establishing of a relationship were raised. Emily (LMC) used to be employed in the same facility that she now transfers into and wants to initiate the midwifery care handover process, but is often met with resistance. Emily believed that the fact she used to work at the hospital affects her experience of handover:

> *I think sometimes the fact that we worked in the hospital, then gone out, we kind of still carry the responsibility for the DHB when in fact we do not have to. It is not our responsibility anymore. So, it's like I really make it quite clear that as per my access agreement, I will be handing over. I feel with a certain coordinator, there is a reluctance to help. Some of the staff midwives just have a generalised view of LMCs, even though they haven't been a LMC themselves, but then some have been LMCs, and they have a way that they think all LMCS should work the way they used to, so it's their personal experiences as well.* (Emily)

Emily believed the fact she had worked in the same facility that she was now transferring into, had influenced the opinion of some of the staff midwives when Emily approached them for handover. The fact that the handover must be done through the coordinator role makes it even more difficult for Emily, and she still feels a responsibility for the hospital. From the staff perspective, they feel that Emily should know how it is for them when she wants to handover. What Emily has experienced is also what Hunter (2003) revealed in her study, that the primary site of tension and stress between hospital and community based midwives is in the interactions amongst colleagues, and concluded that this was due to conflicting ideologies of midwifery practice. Emily knows she does not need to bear the responsibility for the staff situation at the hospital and her clinical responsibility is towards the woman and getting the appropriate care for her. What Emily is

describing was also described by Beth. Beth (core midwife) raised the issue of how some of her colleagues viewed midwifery care handover:

> *Maybe we should get rid of the word "dumping" because dumping is throwing something away that you do not want any more. And is seems to have crept in. Dumping, it is a very negative word and we should really be celebrating transferring them in and by recognising that this is beyond my scope, they have made a decision, wonderful, no good waiting for someone else to make the decision.* (Beth)

Beth challenged the use of the word "dumping" and said it is not appropriate when describing handover of women. On the contrary, Beth thinks that handover of care should be celebrated, as it is the midwife's self-recognition that the woman's care has now moved into secondary care and she does not have the skills to provide the care needed. What Beth is describing here is clarified by Calvert et al., (2017) when she described professional positioning as midwives making decisions and statements around the care they provide. The variation in the skill set amongst the midwives and different boundaries they set around practice activities is what Beth has acknowledged and should be at the heart of midwifery care handover.

Respect Builds Relationships

One of the core values in a relationship is respect and for midwives and their relationships, this was no exception. When respect was being discussed by the midwives it was defined in terms of being polite or considerate, experiencing a sense of being valued or appreciated, or valuing or appreciating the other person; as opposed to having a high opinion of oneself or another person. The midwives interviewed raised the importance of respect being demonstrated whether it was discussing their relationships, communication, assessments, or decision making. Respect was the one sentiment that was expressed by every midwife and referred to when the midwives were reflecting on their experience of midwifery care handover. Beth (core midwife) described what was important to her for a good handover:

> *For me, there are three parts to the pillar of a good handover, respect, trust, and good communication. If they are not all there, if one or the other is missing, then it could quickly end up with a breakdown of the handover situation for some very petty reasons.* (Beth)

Beth's narrative described core values of midwives respecting and trusting one another, and Beth suggested that having trust and respect for each other will lead to good communication and ensure that there is a good handover. If there are missing aspects in this process, Beth implied that the midwifery care handover may not go well. Beth then talked about mutual respect:

> *I think when you are respectful to each other at handover it is very important. So, when the midwife calls me and tells me what is going on and I respect what she has done prior and respect the way that she has approached it and she also has respect for me in the way that she knows that I will do my best to for the woman.* (Beth)

In this aspect of professionalism, Beth discussed how important it is that both midwives respect each other, and that then builds the relationship. At the interface of midwifery care handover Beth respects what the LMC midwife has done prior to the handover. Similarly, this respect is returned by the LMC who has confidence that the best will be done for the woman.

However, Kate raised the issue of respect in a different light. Kate felt that midwives talk about having respect but that this does not always come through when the conversations are being had. Sometimes it is not what is being said but how it is being said:

> *That element of respect is actually - really, really, important. Recently we had a situation where a midwife had transferred in because of failure to progress, the woman had ruptured her membranes over 36 hours earlier and declined antibiotics, the family had declined transfer and by the time that midwife could get her to come in for some care - there was tachycardia with reduced variabilities and at that point we called the registrar and he came through. We speak of respect you know and sometimes it is not how we say things but it is about tone, it is about mannerisms and what we say and how it comes across. I was cringing because from the way the registrar was questioning the midwife and the woman, if I was the woman I would be thinking that my midwife had done something wrong and that was not the case. It's not fair and we have to change this.* (Kate)

The woman and her family had made their own decisions, going against the advice of their midwife. When the LMC was finally able to convince the woman and her family to go into the facility, the doctor did not demonstrate professional respect for the midwife. Instead of getting a handover from one of the midwives and

acknowledging the position in which the LMC had been put, the doctor started questioning both the midwife and the woman. Kate had empathy for the LMC as prior to the registrar coming into the room the two midwives had been working together and made a joint decision to consult. The interface of handover of care between the two midwives had been interrupted and then care disrupted further by the doctor when there was the challenging of the midwife and the woman. Reiger and Lane (2009) stated that while collaborative multidisciplinary teamwork is widely espoused as the goal, it is hard to achieve, especially in maternity care, as there are the professional rivalries and deep seated philosophical differences that produce significant tensions.

Beth raised an interesting issue of whether respect influences both communication and decision-making at the time of midwifery care handover:

> *I think if you do not have respect for somebody, maybe you need to listen more carefully. I often wonder if that not listening sometimes influences decisions - I do not know. Because if you have confidence in them, you will respect them and then you will have good communication.* (Beth)

What Beth is saying is that she thinks midwives need to pay more attention to the handover when there is not an element of respect there; and she raised the question that not having respect for someone will possibly influence the decision being made. Beth believed that good communication could only happen if it was intertwined with respect and trust. Kate's example of the doctor challenging the midwife and the woman would suggest that Beth's statement has some foundation. Dixon (2005) also found that the midwives needed to build respect with every professional at each birth: the professional's judgement will be formed by the perception of the midwife's knowledge and ability. Reiger and Lane (2009) reinforced that maternity providers need trust, respect, communication, and confidence to work in collaboration. Respect was identified as a key factor that can impact positively or negatively on handover of care. Reasons for not collaborating however include distrust and lack of respect between the health professionals, as well as differing philosophies which can lead onto tension and, in turn, miscommunication, resulting in an unpleasant environment for everyone including the woman (Beasley et al., 2012.). It is these attitudes and associated behaviours that have an impact on the handover of care, and the midwives need to turn these unprofessional behaviours around and focus on the positive aspects of the process.

Listening skills facilitate handover

The LMC midwives, when asked what it was that went well for them at the interface of midwifery care handover, all spoke about being listened to. To these midwives it was a sign of acceptance and validation of their assessments of the situation at the time of midwifery care handover. Gina (LMC) highlighted that being listened to, was important to her. "Feeling that I have been listened to and feeling that I am being believed." For Gina, it was important to her that the assessment she had made of the situation and that her handing over was being listened to by the other midwife. It was also important to her that the other midwife believed what Gina was saying and accepted the assessment. Debra (LMC) also spoke about the importance of being listened to:

> *They had listened to me when I told them that I needed assistance for the birth and so they were ready for us. The equipment was in the room and a staff member was there waiting for us.* (Debra)

Debra was in a primary birthing centre when the situation changed dramatically. She contacted the facility she was transferring into and gave the staff midwife further information on arrival to the delivery suite. Debra felt that because she had been listened to, her assessment of the situation was accepted which meant there was no delay with the birth, which resulted in a good outcome.

Amy (LMC) had a similar experience:

> *The core midwife has listened - at the same time she has carried on doing what she was doing. She said- okay tell me what is going on, so I have been able to tell her. I remember another time when the registrar was there as well, they also wanted to know as they had walked in after I had been talking to the core midwife-so I had to repeat it all, but they were listening to me. And so, they asked for the, tell me I am listening to you, tell me what is happening and to give me that space.* (Amy)

Amy appreciated that her assessment of the situation was valuable to the midwife to whom she was handing over. Being listened to was important to Amy and the acknowledgement of the core midwife and the registrar saying, "tell me, I am

listening to you," ensured that Amy gave them all the relevant information for the ongoing care of the woman at the interface of midwifery care handover.

In this research, all three LMC midwives valued being listened to and knowing that their assessments had been believed. They felt this contributed to the midwifery interface being successful. At the same time, it was reinforcement that they were being acknowledged as experienced and skilled midwives. This successful interface contrasts with what Harris et al. (2011) found when they interviewed rural midwives about their experiences of transferring into an urban hospital. While the rural midwives felt confident with their skills in their rural settings, when they transferred in the hospital, and interacted with their urban colleagues, the confidence disappeared, as the urban midwives did not respect the skills of the rural midwife.

In the current study Beth (core midwife) pointed out that for the interface to work well, there needs to be patience and timing until the other midwife is free to be able to concentrate on the information. Beth talked about the importance of taking the time to pay attention to those conversations:

> *If you are incredibly busy and have a lot of things going on and someone wants to come to you with a handover, it might not be an emergency, it might just be a handover, however, you need to pay attention to this when there is only two of you here, and they don't seem to have the patience to wait a moment until my ear is free to commit to listening to them. So, they are starting on the wrong foot. It's that yes, I am listening to you, not you just talking to me when I am completely engaged in something different. So that is not really working for me either. So, for me those things being dedicated to each other, so you know that I am with you and I am with you and we talk to each other to get the most relevant information which is what I wish everyone could do.* (Beth)

Beth is aware that the LMC giving the handover needs to be listened to and valued, but sometimes she feels that the other midwife wants to interrupt her. Beth finds it difficult to accept a handover when she is already concentrating on something else. Beth acknowledged that the two midwives both need to be in a position of being focused and engaged in the conversation. Fealy, Munroe, Riordan, Croke, Conroy, McNamara et al. (2016) highlighted what Beth has described as a major barrier to effective clinical handover. The interruptions and the setting could also limit the amount of information being shared, and considering that the handover is also a transfer of clinical responsibility there is a potential risk to patient safety and quality

of care. Therefore, to ensure there is a positive handover experience between the midwives and a safe handover for the woman, the midwives need to take the time to listen and focus on the information that is being shared.

King and Hoppe (2013) stated that communication is a fundamental aspect in the provision of healthcare with evidence that healthcare professionals often lack effective communication skills. Kilner and Sheppard (2009) described effective communication as the face to face conversations, the telephone conversations, and the documented text in a medical record, and went on to say that effective communication is essential to teamwork and patient safety. In addition to these elements of communication, Dalonges and Fried (2016) added that a part of all communication is the nonverbal behaviours and how these nonverbal gestures can influence outcomes. Phutela (2015) also acknowledged that nonverbal gestures can lead to misinterpretation and when a person displays negative nonverbal gestures, such as rolling of the eyes, moving quickly or other negative physical behaviours, it can act as a communication barrier. Gina (LMC) gave an example of how body language can result in a negative handover of care. Gina described the situation when she was trying to handover:

> *There is nothing worse than eyes rolling and going "oh, right, so she just needs an epidural for pain relief." No, she has been in latent labour for the last two days and she has been in established labour for 16 hours and she is still not fully dilated, this is not just an epidural, something is going on here and she needs some help.* (Gina)

Gina expressed her frustration when the midwife receiving the handover focussed on one aspect, the epidural, and did not acknowledge the bigger picture. Gina described "eyes rolling" at handover suggests an element of negative judgement towards her practice. Gina experienced what Phutela (2015) had described. This was a good example of two people talking past each other; where one party thought they knew what the situation was without really listening to the other person. This can be interpreted as demonstrating a lack of professionalism but also demonstrates how communication affects a relationship which negatively impacts the interface at midwifery care handover.

Beth (core midwife) expressed a strong desire to get all the negativity that happens around midwifery care handover stopped and move forward:

> *I also think if you are working in a team environment, you cannot have an unpleasant conversation that is loaded with negativity regarding the LMC handover, and at the same time expect to have a good team environment to work in. It causes anger, frustration, and the negativity carries itself over and then there is a tension that has been created. So, if you want to have a good day, and a good team working environment, then you need to think, we are going to do the best that we can altogether. If everyone works together and pulls their weight, and then if someone feels like they are having a wretched day, we can lift them up and go together, and that can only be achieved if we cooperate with other people who come in briefly and then go again. Stop forming opinions and just because they come in from the outside, and need to handover we do not decide we do not like you. That doesn't work.* (Beth)

What Beth has raised from her observations is the impact on a team when there are negative conversations about the LMC midwife handing over. Beth believed this causes more stress and frustration and it could be avoided. She described what she would like to see with everyone pulling together and then, if someone is having a bad day, all get together and lift this person up. Beth says that when the LMC midwife comes in briefly and then hands over, this does not mean that opinions should be formed or voiced about that midwife. Instead the team should focus on cooperating and working collaboratively together to ensure that the handover process is not compromised by negative conversations and the focus remains on ensuring the woman is safe throughout the process.

Collaborative Care

Midwifery care handover requires collaboration, and to achieve this the relationship needs to be established. The midwives in this study have all placed emphasis on having relationships with their midwifery colleagues. The midwives have linked relationships to communication and having those two factors, as well as trust and respect, as the foundation of working collaboratively together, as primary care interfaces with secondary care. Downe et al. (2010) explained that collaboration is important when the woman crosses over from low risk to high risk, and that it is at these points differing philosophies can bring tension and even resentment. Beasley

et al. (2012) described collaboration in maternity care as a dynamic process of facilitating communication and trust that enables the health professionals to provide safe, woman centred care. To build a professional relationship and work in collaboration, the midwives interviewed in this study felt there needed to be an element of understanding of where the other person is at, when two midwives come together for the handover of care. It was positioned as taking the time to step back and consider the other midwife and the journey she has just been on. Amy (LMC) identified this in the following excerpt;

> *What matters most to me is that they do not judge me for the condition that the woman is in, that I am handing over when it is an emergency situation. We all do our best and I do not need to be judged for what I haven't done. There needs to be an understanding that every midwife tries to do her best and what you are presented with at handover is the best that I have been able to do at the time. If she has an IV line in you are lucky, and if she hasn't got one in it is because the ambulance was waiting and the fetal heart was doing things that I do not like, and transferring is more important than getting that line in.* (Amy)

Amy felt that all midwives tried their best at the time of an emergency. However, at times they feel they are judged on what they have managed to get done or not done prior to the handover. Amy needed acknowledgement for the fact she is a rural midwife transferring in and she had really done the best that she could under the circumstances. Working collaboratively together to provide care for the rural woman when they transfer in, requires the midwives to be supportive and respectful of each other, not critical of what tasks have or have not been completed. Collaborative care ensures the woman is kept safe and the midwives are working together to support the woman.

Beth (core midwife) identified appreciation for midwives that work in the remote rural:

> *If they are ringing me I am going to acknowledge that they are worried, they are not incompetent. It might be something that they cannot put their finger on, but they are worried and ringing me for a second pair of eyes that I cannot give but I can give a second opinion, something to discuss. Even if it is a gut thing that they think they are just not happy, I am not going to argue with that, I acknowledge they are in a remote area, way up ... if they are there, it is a very long way to find help and if they are ringing*

me and they want a second opinion, or they want help I am going to really acknowledge that. (Beth)

Beth's appreciation of the remoteness in which some of the midwives' work, and how she supports them, shows the professional recognition that builds relationships central to handover of care. This collaborative support contributes to a positive experience of interface that will then make a smooth pathway if the decision is made to transfer in and requires a midwifery care handover. Cindy (core midwife) described the strategy she takes when she receives a phone call from the midwife out in the community discussing the possibility of a transfer in:

> *Some colleagues saw it as a them and us, but I thought we are all one team and right from when I get my first phone call, I try to portray that when we are discussing things we are actually a team. I acknowledge that you have skills that I do not have, and I've got skills that you do not feel confident with. I know if someone asks me to do a water birth, I would be just out of my depth because my journey has never taken me there. It's not that I am philosophically opposed, I just haven't had the experience and confidence and it's just the way I have been and just haven't done that and I totally acknowledge those midwives that do homebirths and water births.* (Cindy)

Cindy felt that whenever she received a phone call from an LMC midwife that the discussion needed to be one where the two midwives worked together as a team to achieve a solution to the ongoing management of the woman. Cindy acknowledged that midwives all have different skill sets and it is experience that takes midwives off in different directions. However, that does not mean that one midwife is better than the other because of what she can offer to the woman. This type of acknowledgement between midwives appears to reflect an attitude which is key to a good handover and working as a team with both the LMC midwife and the woman supported in the transfer of care process. As Cindy described, we are all on the same team but there is also strength in each midwife bringing her own skill set into the situation. Cindy portrayed respect and trust to her colleague and an idea that they are joining their two skill sets together to support the woman. Beasley et al. (2012) stated that working in collaboration entails shared decision-making when each member holds equal power in a non-hierarchical model. Similarly, Cindy viewed her role, from the point of receiving that phone call from the LMC midwife, as a

need to work in collaboration. This ensures that the handover is about managing a safe pathway for all the members of the team including the woman.

Gina (LMC) also spoke about part of collaborative practice is also having an appreciation of the situation of the staff in the facility when arriving in the maternity unit:

> *The community midwife when she comes in, must have an appreciation of what could be going on for the hospital, because when you come together like this, neither of you know what has happened in the last half hour for the other person.* (Gina)

When each other's role, including the context in which the midwife is practising, is not appreciated, this can create stress and added tension at the interface of handover. The LMC midwife coming into the unit is dealing with her situation, she could be quite stressed about the woman and baby, and so her focus is on their immediate needs. Concurrently, the core midwife is dealing with another situation and her focus is on what is facing her at the time. Bring the two midwives together and that is when their worlds can collide and potentially result in difficulties at the interface of handover of care. - Hunter (2003) stated it is important to acknowledge these conflicting principles as a primary source of emotional difficulty and address them.

Cindy (core midwife) described a recent scenario where she felt her practice reality was not appreciated by the LMC midwife:

> *We can always, the potential is always to get that emergency transfer with a midwife and we had one recently with a very experienced LMC who rang up and said second stage, pushing, and fetal heart at 60, we are transferring now. There was not time for anything else, that was perfect, you got what you needed, and she said have the team ready and so that was enough. So even over the phone I could get an idea and I knew once she was in the ambulance she was 5 minutes away and how long the fetal heart had been at 60. So, when she came we had all the people ready with the doors open. I kept trying to get the doctor down for the midwife before she got to the room, we got the CTG on it was still at 60* (fetal heart) *and she turned around and says; where's the doctor. I thought, you do not really understand what's it like here, we have 100 other things going on here, even though you wanted the doctor right here in the room at your moment of arrival and unfortunately, she isn't she is upstairs. She's coming, so the midwife was really stressed and rightly so as you could see a fetal heart at 60. I knew that she had given me enough information, that she was unhappy; it wasn't*

just a new midwife who wasn't maybe tracing properly it. It was an experienced midwife and I knew that this was a true emergency situation and, so I was trying to get everything organised for her. (Cindy)

Cindy's description is a further example of what Gina had been referring to around collaboration between midwives. Cindy has the experience that enables her to appreciate the situation the LMC midwife is in. She is dealing with a fetal bradycardia and the stress that this is causing her as the woman needs medical assistance promptly. However, Cindy is under the same amount of stress as she had been trying to get the doctor down to the labour ward as soon as she had been called about the transfer. Both midwives are in the same situation, but what Cindy is implying is that the LMC midwife did not appreciate she had been trying to have everything ready for the transfer in but unfortunately the doctor was attending another emergency elsewhere in the maternity unit. Cindy knows the doctor will get to them as soon as she is able; Cindy has informed the obstetric team about the situation that is transferring in. This situation is difficult and frustrating for both midwives, but it is a situation that neither midwife can remedy except to support each other and the woman until the doctor arrives.

Gina gave a good example of appreciating each other's roles:

I wanted to handover, but the midwife had come on to do half a shift, bless her heart, knows me well and on numerous occasions had to put me off and say I am trying to get some staff, I'm trying to get you out of here and get you some sleep or whatever. So, she knows that I am tolerant of delays and she came in and said this is what I am dealing with and showed me a piece of paper saying 4ᵗʰ degree tear in this room, possible emergency section coming in from this area and she said you are third on the list and I cannot take the handover. I took a deep breath, you're buggered, and I know what you are dealing with and I know you are doing your best sort of thing. She came back 5 minutes later and said if you can pop in on that lady with the 4ᵗʰ degree tear every 15 minutes, I can get the core midwife in with her, to come and do the epidural. So, you know what? We kind of worked away around it because she knew I could handle I can tell if a 4ᵗʰ degree tear is bleeding. Again, it may not fit entirely with their protocols having an LMC checking on someone but needs must. To create a better situation overall sometimes you have to shift your individual things a little bit and juggle them a wee bit. That's a good example of being collaborative and even though we didn't need it in the end, because the anaesthetist had to go to theatre, but if he hadn't had to go to theatre right then, we would have got ourselves sorted – it was still a positive experience. (Gina)

What Gina has described here is an appreciation of her colleague's situation and being prepared to work with the core midwife to get an epidural for the woman for whom she was caring. Not only was there acknowledgement and appreciation of the pressure for each other, but both midwives demonstrated respect and trust for each other which led onto collaboration. As Gina concluded they did not need to implement the process they had discussed but she still felt it was a positive experience due to the willingness of both midwives to work collaboratively.

Conversations matter

The types of conversations that are had about health professionals have the potential to create a positive or negative environment and impact on handover. Cindy (core midwife) reflected how midwifery relationships can be influenced by the conversations that take place with other professionals and shares one such example:

> *So that comes back to a relationship with communication, it's a big thing. It's the culture that conversation bubbles underneath all the time. We have doctors that go and work in other DHBs, and then they come back and say I cannot believe what you are letting the LMCs get away with. It doesn't happen in other places. How can you let them, cannot you make them come in and do the care for their woman?* (Cindy)

Cindy suggested that these types of conversations start to sow the seed of doubt and can be the catalyst that undermines professional relationships amongst the midwives thus creating barriers for midwifery care handover. The hospital midwives feel like they are being challenged about letting their LMC midwifery colleagues "get away" with practice that is not a national trend and that the doctors are suggesting they are being taken advantage of. This can cause tension, especially when the hospital midwives feel like they are already working at capacity. It is these uninformed conversations that impact the trust and foundation of the relationships, which are contra to good handover of care between midwives.

Beth (core midwife) raised the issue of how medical colleagues' communication and behaviour can have an impact on the midwife that is transferring a patient into secondary care, and she felt that this was not professional or helpful:

> *Sometimes our medical colleagues can influence the situation because they have this, this little circle of friends, and make statements like "this one here - you do not trust." They would ask "who is the LMC that is coming*

in" and then someone would say the name and then someone else would say "she is good". You cannot say she is good just because she works under the model that you like or what is good about her or not good about her - and who are they to judge? (Beth)

Beth was not comfortable with how some of the doctors made statements that often belittled a midwife because she was not in their circle of "good" midwives. Beth felt that the doctors were judging a midwife's performance on how compliant she was with their way of doing things rather than on the midwife's ability. Beth felt that their judgments were then passed on and decisions were made based on their judgements of the midwife rather than the actual situation they were being asked to consult on. Beth's experience is described by Reiger and Lane (2009) who reported that the doctors' views of what made a good midwife, was someone that was skilled and could be relied upon to work as part of the medical team, and a really, good midwife will let you know when they are needed. This type of unprofessional behaviour of the doctors can be a barrier to the midwife coming in to handover. Borrelli, Spidy, and Walsh (2016) asked the question from first time mothers what they thought made a "good" midwife. These authors concluded providing information, promoting individuality, having a physical and immediate available presence, and relationship-mediated were factors comprising a good midwife. Nothing to do with being part of a medical team; more about being woman centred which is what midwives need to be at the time of handover of care.

The Rural Midwife

Rural midwives have extra considerations when there is a decision to transfer and handover, in comparison to their urban colleagues. There is the distance to travel, which impacts on the decision making regarding when to transfer in, and additional frustrations and considerations of being able to get back to their community. While some of these considerations are around service design, they do have an impact on the handover process for the rural midwives. Beth (core midwife) described the lack of understanding by the medical fraternity of the geographical situations that some of the rural midwives worked in and the difficulties that faced them:

Some people can put themselves easily in the shoes of others - but others struggle with that - they only know their own work environment. We often see this with new registrars coming into the region. They have no idea it is

2½ hours' drive in an ambulance, over regions where you do not even get cell phone connection - they think the midwife is just down the road. (Beth)

Beth had witnessed discussions by doctors where they had the same expectations of all the LMCs, with no insight of the stressful situations under which some of the rural midwives worked. Beth felt that this came down to the fact they did not know the demographics of the DHB in which they worked. It is this lack of knowledge and understanding that causes added stress for the rural midwife when she is transferring in, and does nothing to build or establish relationships that makes handover work well.

Amy (LMC) and her colleagues have been accused of "dumping" the woman when they transferred into the facility:

> *We have heard through other people, the gossip about us, the rural midwives - they accuse us of just coming in and dumping our woman and then taking off again. Now I think they are becoming to understand why we cannot stay with our woman due to our commitment back here. The ambulance officer we came over with only gives a limited time to handover or we must pay $250 for a taxi to get home. I think the hospital midwives get it now… after how many years? Finally, finally got it that we need to come in handover and then go back.* (Amy)

Amy and her colleagues had been told by other midwives that this was the conversation that transpired following their midwifery care handover. The reality for these rural midwives is that they provided the escort in the ambulance, but they needed to get back to their rural area where they provided cover. The interface at handover has improved for Amy and her colleagues as there is 'finally' an understanding of the reality and challenges for these rural midwives.

Cindy (core midwife), on the other hand, celebrates the rural midwives' handover and spoke about the benefits:

> *My job is really interesting and because of that interface, I am busy, busy, busy and sometimes it's a good thing that woman have to wait for pain relief as they go on to deliver and I get to do lots of things because the primary units are quite rural. The woman might be pretty normal, but then spikes her blood pressure for example and they have to transfer her in, she then goes on and has a normal delivery. But because the midwife must go back in the ambulance I get normal as well.* (Cindy)

Cindy celebrated the fact that due to the rural midwives handing over she was able to care for women that then went on to have normal births. Cindy has an acceptance and an understanding of the context in which rural midwives practice. What Cindy does is turn the situation into a positive one. It is a win-win for the midwives and, at times, the women go on to have a normal birth. This is a good example of what works well at the interface of midwifery care handover.

Gina, on the other hand, who prefers to stay on and support her woman, when there has been a handover of care, reflected on how things used to be in the past, and had experienced difficulties in getting back to her base.

> *We didn't used to have any way to get back, I have been in an ambulance, then they get a call and I had to get out and hitch a ride. I had stayed on and supported the staff and the woman for 25 hours and then I had no way to get home. I had, had a gut full, and I had asked and asked how am I supposed to get home now and no-one could tell me. A senior midwife contacted me and she has now got this sorted so it is no longer an issue for us.* (Gina)

Gina stayed on to support both the woman and the hospital staff; however, she then found herself in the situation where she was unable to get home. Gina's concerns regarding transport home are a reality for her and her rural colleagues and not often appreciated by the staff midwives. This is no fault of the core midwives as they manage to get themselves to work and home again, and often it is not until someone raises an issue that there becomes awareness. What Gina did was raise the awareness of the issue for her and her rural colleagues and a solution has been found.

Support for Midwives coming into the DHB

Beth (core midwife) suggested that sometimes there also needs to be a consideration for the people that are coming into work areas as they do not fully understand the processes that staff takes for granted. When working with processes within one's own work environment, one has a good understanding of how things are done:

> *When we work in here we're used to the processes around the DHB and when other people interface with us they do not have nearly any understanding of the process. We assume they do, but we just think that everyone does because we know it inside out.* (Beth)

Beth acknowledged that there is an expectation that everyone knows the processes that happen within the hospital setting; but in fact, it is an assumption. The hospital midwives need to accept that the situation is different for them compared to those who are transferring in or handing over care. It is these types of assumptions that can cause frustration and tension at the time of a handover as there is the expectation that everyone knows how things are done. When midwives do not know, there appears to be very little tolerance and an expectation from staff that they should know.

Supporting the New Graduate

Relationships are even more valuable to the new graduate midwife, especially at the time of transfer or handover. While the experienced LMC midwives could articulate the information to the hospital midwives Cindy (core midwife) demonstrated empathy for the new graduate LMC calling in for support:

> *What I really appreciate is when the new grads will often ring and say hi -*
> *I am a new grad midwife and this is my issue. So, you know immediately*
> *that you are dealing with someone who might be feeling really scared to*
> *ring you about something that they think might be a bit silly - but thank*
> *goodness, they are going to ring me and ask me for an opinion, because*
> *that is what I want open communication, you do not want people hiding*
> *things because they are too scared to ring the hospital.* (Cindy)

Cindy demonstrated she had insight to how a new graduate could be feeling when she is ringing into the facility seeking advice. There was a sense of responsibility and professional pride as she spoke about the new graduates and how central her response was to ensure there were no barriers to the new graduate midwives ringing in and getting advice so that they could feel safe and continue to ring in.

Beth also raised the issue of the new graduates:

> *You lead by example in whatever you do and they (the new graduates) will*
> *watch you and they will hear what you say and they will see if you roll your*
> *eyes and they will see if you are being respectfully when asking questions*
> *and that will make the difference how they might approach things in the*
> *future because they see it as a clever conversation instead of some power*
> *game.* (Beth)

Beth raised the importance of setting a good example to the new graduates that worked in the facility; she felt that her behaviour is what the new graduate midwife would mirror when taking a midwifery care handover. Beth wanted to show the new graduate midwife that it is not all about a power game but the response of a midwife showing respect to her colleague when they interfaced for midwifery care handover. As a senior midwife Beth wants to show the new graduate midwives how important it is to have the relationship with their colleagues and she is also demonstrating a good example of how it should be at the interface of midwifery care handover. Both Beth and Cindy have raised the importance of supporting and being role models to the new graduate midwives. Kensington, et al. (2016) concluded that graduate midwives identified they received support from the whole of the midwifery community, and it was this midwifery community that was seen as a resource that provided reassurance and encouragement in a collegial and collaborative way.

The Midwifery Care Handover Debate

Beth (core midwife) explored the complexity of this issue:

> *We need these community midwives, as each person has their own tasks. Even within our own workforce, some midwives are wonderful at breast feeding and postnatal care, they do not actually want to go and look after the complex woman. I think it is important, we need to have a good relationship with our community midwife because she is going to pick up and do that community post-natal care, because we are not going to do that. She doesn't want to do the complex care I do not blame her, but please, tell her what happened to the woman so that she knows. That is why interfacing and handover is so important and keeping the woman in the community and don't make the hospital a prison. The woman will thank you for it and we will have enabled all the people that care for her to have the best information that they can have, and they benefit from that. It's the true partnership model rather than ownership model. We must mirror that as midwives and keep trying to say that I am in partnership with you.* (Beth)

Beth has a strong belief that there is a role for each midwife and that it needs to be recognised and supported as part of the journey for the woman. Beth talked about the importance of having a good relationship so that when the woman transfers back to her LMC midwife, the midwife has all the information and can provide the ongoing care for that woman. Beth wants to see a change in attitude, and build those relationships so that all the midwives work together. It is not about measuring

another midwife on the type of midwifery care she chooses to provide. Hunter (2003) argues that midwives need to acknowledge the conflicting ideologies and accept that there are different types of midwives, whose work is underpinned by different ideas and values and they prefer to work in different settings. In New Zealand, it is the midwives themselves that choose to be either a core midwife or an LMC midwife, however all midwives practice on their own authority and are accountable for their practice. The core midwife has the role of caring for women when they are admitted with complex care needs and partnering with their LMC colleague to provide care to these women. (Gilkison, Pairman, McAra-Couper, Kensington, & James. 2015). Gilkison, et al (2017) expressed that core midwives sometimes feel they are invisible and undervalued but argued, from their research that core midwifery is fundamental to the effective functioning of New Zealand maternity services. The midwives need to feel valued for the midwifery care they provide regardless of whether they are a core midwife or an LMC midwife, both roles are an important part of the woman's journey. If the two roles can come collaboratively together, and work as a team, at the time when the woman's care has changed from primary to secondary care, this will create a positive environment for the interface of midwifery care handover. The focus needs to be on what the woman needs at the interface of midwifery care handover, and an agreement between all parties as to which midwife is the best midwife to provide the care at that point in time. This ensures a smooth pathway for the interface of midwifery care handover.

Summary

The importance of establishing professional relationships between midwives has been acknowledged by all the midwives, and it is these relationships that impact the effectiveness of the midwifery care handover. To build the relationships there needs to be positive communication, and the midwives also stated that respect and trust were essential principles. The LMC midwives felt validated when they were listened to at handover and this made the experience of midwifery care handover a positive one for them. There needed to be an appreciation of the different roles for the midwives and an understanding from the new graduate's perspective. There were no new graduates interviewed but the midwives interviewed asked that there be consideration for them. The midwives interviewed could detail their experience of positive and negative responses at the interface of midwifery care handover.

Chapter Six: Processes and What Works at the Interface of Midwifery Care Handover

This chapter looks at what processes the midwives have identified that support the transfer of a woman into a facility, and the interface of midwifery care handover. While the current process may not be perfect every time, it has been acknowledged by the midwives that it is a vast improvement of how they used to work.

The midwives themselves all raised and endorsed the introduction of an Associate Charge Midwife (ACM) role. This role had been introduced when the DHB identified the need to employ changes to ensure that LMCs and primary birthing staff in their region could easily and quickly contact obstetric and neonatal teams in an emergency. This senior midwife role holds the emergency phone for all incoming emergencies and transfers into the facility. The ACM has the responsibility of overseeing the midwifery care handover such as epidural and is the "go to" midwife for handover and all transfers. In addition to the ACM role, the DHB also implemented a transfer of care procedure to safely manage primary/secondary interface in a clinical setting. Included in the implementation of these changes a communication tool was introduced.

Associate Charge Midwife Role – LMC Midwives Perspectives

The introduction of the ACM role was acknowledged by all the midwives. For the LMCs transferring in, this role has had a positive impact. Gina acknowledged the benefits of the ACM role for her:

> *We used to have to make two phone calls. We would ring the registrar, and then they would ask us to ring the coordinator and let her know, very difficult when you have a fetal heartbeat of 80, so no I cannot. Now we ring the ACM and we go through the situation with her. It is so much better now, we are only making that one call and then it is the ACMs job to involve whoever else needs to be involved. It's just the time saving, and I think because it is only one call you make sure you have provided all the information.* (Gina)

Gina compared the process she uses now, the one phone call to an ACM, compared to when she used to have to first ring the registrar and was then expected to make a second call to the midwife coordinator. Having to make the extra phone calls was

stressful for Gina who was trying to manage an emergency; being expected to repeat the information left room for errors because there was the possibility to leave out information on one of the phone calls. She found the new process so much better and a lot faster. Gina was also more confident with only having to tell the story once – she has not forgotten any information.

Amy, another LMC, also endorsed the benefits of the ACM role and the difference it has made for her:

> *Yeah, like before we were making 3 or 4 phone calls. I would ring the secretary and I would tell her first and then if I didn't tell her first, and I had rung delivery suite or talked to the registrar and then they would say would you let the midwife or manager for delivery suite know and then I would think, I haven't talked to the secretary cause sometimes then we would arrive over there, and they weren't expecting us and I had made 3 phone calls but I hadn't told the secretary. I learnt. No, it has made a big difference.* (Amy)

Amy also found the former process of ringing three or four people quite stressful. She would question whether she had informed all the appropriate people at the time. She also found that those calls took time, and diverted her away from focusing on the emergency in hand. Amy also learnt from experience what happens if the right calls have not been made. If someone had been left out of the loop there was potential for key people not knowing about the transfer and not expecting them. Now Amy only makes the one phone call and is confident with the process:

> *Now when we realise we need to transfer, the first thing we do is ring the hospital and talk to the ACM. It's a really good system. Having the ACM cool calm and collected is very valuable because sometimes you have a situation where you are just going through in your mind how am I going to get them to the hospital? Or else you are thinking, could someone die today, you know no-one is going to die today and they never do. They get it that I am here on my own. It's having the one designated person to hand over to on the phone. The difference being we used to phone in to a clerical person and if they did not appreciate the situation I am calling in about, then it became very difficult. Those ACM midwives are all really good.* (Amy)

Amy values being able to speak with an ACM who is 'cool, calm and collected' because she already has the stress of working out how to get the woman safely

transferred. Amy also felt that they appreciated the fact that she was on her own managing the situation and that the calming influence the ACMs portrayed then supported her through the situation. For a midwife on her own dealing with an emergency can be a very stressful situation to be in, and Amy found the ACM's calm disposition was exactly what she needed at the time.

Debra also found the new ACM role worked well for her:

> *I pick up the phone, I do not have to worry about who is on the other end of the phone, that used to influence a lot of information and things before. Now, I ring in, I have got one person I can say what it is and I can carry on caring for the woman and get the transfer in. The ACM role has made a huge difference and it's very noticeable when there isn't a ACM on and the response can be diffe*rent *because they haven't quite got the same skills.* (Debra)

Debra found that having the confidence in the midwife that answered the phone meant that she could state exactly how things were and not have to worry about whether she was being understood or if there was a need for further explanation. In the past Debra found that her decisions and information sharing was influenced by the person in the other end of the phone. However, only having to make one phone call now leaves Debra free to concentrate on getting the woman ready for transfer and into the maternity unit where there is the obstetric support that the woman requires. Debra can compare the difference between the midwife that does the ACM role on a regular basis and a midwife stepping up to cover the role. The permanent ACM has a skill set that supports the midwives transferring in and while the midwives acting in the role did have some of the skills, they were not quite as experienced.

Emily, on the other hand, felt her experience with the ACM role was influenced by who was on at the time of the transfer:

> *It tends to go generally well; it goes quite smoothly now that they have a new system, where you get the ACM answering the phone. It depends a lot on who is on and what their personal agenda is. There are certain ones that will always seem to be consistently reluctant to accept midwifery care handover. Sometimes they may not pick up the phone but if it's urgent then I ring the delivery suite receptionist and tell her we are on our way.* (Emily)

Emily knows that her handover of midwifery care is going to be dependent on which ACM was on duty, as she had found certain ACMs that are reluctant to help. Emily used her knowledge of the unit and would call directly to another person, such as the receptionist, if the ACM was not picking up the calls for whatever reason. While this could work for Emily, the calling into someone other than the ACM is an issue that two other LMC midwives raised regarding talking to someone that did not appreciate the situation the midwife was in.

From the LMC midwives' point of view, the ACM role generally works well for transferring in and handovers; having one point of contact has made a big difference to the whole process – only needing to make one phone call instead of two, not having to give the same information repeatedly. This reduces the risk of omitting relevant information that could impact the safety of the woman or her baby. Only one LMC midwife reported that she felt some decisions for handover were delayed and this was dependent on which ACM was on duty when she phoned in.

Associate Charge Midwife Role - Core Midwives Perspectives

While the LMC midwives have noted the difference with the ACM role for the transfers and handovers, the core midwives also spoke about how the ACM role supported them in preparation for the LMC midwife transferring in or handing over care:

> *The LMC midwives ring and they talk to the person who is in charge, which is the ACM, and they give them all the information about the woman coming in, usually a very brief conversation. They hang up and then the ACM talks to all the relevant people who accept the woman, or the baby or whatever it is and with all the information collated they then go back to the primary referrer with the relevant information. It is always the same people talking to each other so you do not need to repeat yourself so there is less misunderstanding of the situation.* (Beth)

Beth has found the role of the ACM works more efficiently for her as she knows exactly what is needed for the transfer in and is then able to have everything in place for the LMC midwife and the woman on arrival. Having one person managing the situation means there is clarity around the situation and supports a safer transfer and handover for the midwife and the woman. Beth gave an example of what happens when the ACM role is not appreciated, and the process is not followed:

There have been some experiences, only a few, where medical professionals were unhappy to talk to the ACM, because they did not feel a midwife was competent to take the handover. That has ended up with them making a phone call directly to their consultant colleague and that's when everything just goes down the drain. They have no concept of the bigger picture, and they do not take all the information that is needed and that's where it just falls to pieces. That's when handovers from outlying units to this unit become mucky and all muddled and then that's when it does not go very well for everyone. (Beth)

Kate also finds having the ACM role generally works well:

We have developed the ACM role; it's probably about two and a half years old now. They hold the emergency phone and then for example if it is a PPH (post-partum Haemorrhage) or an APH (ante partum haemorrhage) the ACM will call the theatre team including the anaesthetist and the registrar and they will sometimes actually be in theatre ready and waiting. The ACM role have become that one point of contact which seems to be working really well, sometimes if it doesn't work well it is when the staff midwife is really busy and hasn't quite listened to what the ACM is telling them. (Kate)

Kate talks about the midwives in the ACM role having the experience and skill required when taking that emergency call and knowing what is going to be needed. The team responded to the ACM's call and are then ready for the midwife and the woman transferring in. The handover has been given over the phone to the ACM by the midwife and having that one point of contact means that one person is coordinating the transfer and handover so when they arrive at the hospital everyone knows what they are dealing with. Kate also discussed what the process used to be like:

Because I know what happens when they do a doctor to doctor request for transfer in, and quite often the obstetricians aren't that good about relaying all the information back to delivery staff, nobody knew what was happening, so what we've developed is the ACM role so there is one point of contact and one person coordinating all the transfers and handovers. (Kate)

Kate, like Beth, feels the ACM role is a big improvement on what used to happen for the transfers in and the handovers. Cindy echoed the sentiments of Kate and Beth in regard to the benefits of having that one point of contact:

We do now have an appointed role of ACM which is acknowledged and paid properly. Prior to that it was midwives stepping up to coordinate a shift and answer the phone but now we have the ACM as the single point of contact. (Cindy)

The hospital midwives support the ACM role and have found, from their experience, that by having one point of contact the transfer or midwifery care handover could be coordinated and the staff were then expecting the midwife and the woman when they arrived. This supports the midwives at the interface for midwifery care handover.

Communication Tools

The DHB had implemented SBARR, a communication tool, in 2015 as a change to their transfer of care procedure, to safely manage primary and secondary interface. SBAR is an acronym for Situation, Background, Assessment, and Recommendation but in a lot of health care areas they have added an extra R for Response. All the midwives referred to the use of a communication tool and commented on the benefits of having a tool. They felt the use of the communication tool supported the notion of making communication appropriate and relevant.

Beth explained the rationale behind the use of SBARR:

We are encouraged to use SBARR as a handover and I think it is done extremely well by some people and then some people do not use it at all. Some people also use it extremely well for their written documentation and that is the tool that we are encouraged to use. It is quite a simple tool and it could be ICE. I thought we would have had better use of it considering it was part of our midwifery tech skills a couple of years ago. It has been around for a long time and now some people are now introducing it like it is a new tool. (Beth)

Beth supports the use of the SBARR tool and acknowledges that some people use it well and others do not use it at all. As Beth noted, SBARR is a simple tool and even though they use it, they could use any other tool such as ICE (In Case of Emergency). Beth thought midwives would be using SBARR a lot better than they had been, as the SBARR communication tool had been part of the Midwifery Council's mandatory annual recertification programme that all midwives had to

attend to renew their practising certificates. Beth felt that the SBARR was useful for midwives, as midwives tend to give a story when the ACM just wants the facts at the time of the handover:

> *Well I think those communication tools like SBARR works quite well if people follow them. I think as midwives we tend to tolerate story telling because we like stories, and we like to listen to stories, but when it comes to handover story telling needs to stay in the background, and just stick to the information about the handover.* (Beth)

Beth concedes that as midwives we like to listen and tell stories but, at the time of handover, all she really wants is the information that is pertinent to the handover.

Cindy echoed Beth statement:

> *I need clear communication, I need to know what the issue is…. it is really prickly when they start giving you a long-winded history, so then you ask what the issue is? But that is where the SBARR structure is really useful. What is the issue now? Give me the background, them being clear about telling me where they are at, and giving me an idea what they might be facing. I can show my respect for their experience and assess what they need from me.* (Cindy)

Cindy wants the information at the time of handover to be clear and finds the long-winded history of no value. By using the SBARR structure Cindy can get a better understanding of the situation that the midwife is calling about and can then support the midwife with the transfer and handover. Cindy also felt that that if the information was clear from the LMC midwife she could get a better understanding of what that LMC midwife was expecting from her in relation to her experience. Kate (core midwife) also found using the SBARR tool helpful:

> *I think on the whole using the SBARR tool is really helpful in the case of an emergency. The communication needs to be quite specific and the needs to be on both parts - not just the LMC. If you get a precise communication from the midwife in the community, in terms on what has been happening during the labour and the sense of urgency of the situation. It is for me it is a record of events of the story to request the transfer in.* (Kate)

Kate supports the use of the SBARR tool, especially when there is an emergency – it is now when the communication needs to be specific. Kate, as a core midwife, is reliant on the communication from the LMC midwife so that she can assess the

urgency of the situation and have everything in place for the midwife and woman when they arrive at the facility to manage the emergency.

Amy (LMC) equally embraces the use of SBARR as she has found this supports her when she is calling in for a transfer:

> *We ring the ACM and just do the SBARR - situation, background and if I'm too busy getting the woman ready for transfer, she says now just tell me the situation, they are very good and very well trained and do the SBARR really well and bring you back to the steps. So, you know you do the SBARR thing, situation, background and why we are sending them. The ACM and SBARR are working really well, and when they are succinct and clear and the more panicky we are, the quieter and the more informative they are, the better.* (Amy)

Amy finds the process for transfer is a lot smoother with ringing the ACM who then uses the SBARR communication tool. The ACM can prompt the LMC to give the relevant information and get a clear understanding why the LMC is transferring the woman in. This is the support that the LMC midwife dealing with the situation in the community needs. Amy feels the combination of the ACM and SBARR tool is working well and, from her perspective, when she is in an emergency and already feeling very panicky, having the ACM remaining calm and helpful on the end of the phone is reassuring for her and supports the transfer process. Panic and stress can lead to mistakes being made which then increases the risk for the woman.

Debra also advocates for the use of the SBARR tool as a LMC at the time of transfer:

> *You need to go back to your SBARR, what is the situation, what does this mean, the main reason you want to consult or transfer, and try to be quite succinct about the SBARR. Why I am ringing, I am ringing because she has pain, then you can go backwards, and this is the background to it. Giving too much information at the beginning, things can get lost with too much information and trying to strip it into simply, simplicity. You will be amazed how many times that has come up – give me all the facts and I will have the nice to have afterwards. I think that is a nice way of describing it.* (Debra)

Debra explains how she uses the SBARR tool and how it supports her to give concise information to the other midwife. The person receiving the information needs to act on the information that is being handed over and, so it is important that person knows exactly what he/she is dealing with. Debra also agreed that giving too

much information at the beginning means important information can be lost; it needs to be simple or, as she has been asked before, give the facts first and then you can always give the nice to know later.

Gina (LMC) has used SBARR for many years and says the key to using it is staying calm:

> *Primarily it would be SBARR. They have really emphasised that in the last five years or so and it really works well, if we are all calm enough to do it. SBARR just covers everything and it makes it easy and concise and you get your handover more quickly and they are accepting it as SBARR as well and if you go too far and you go to B before A they (ACM) will pull you back. You think yeah, I've got to go back and do it properly.* (Gina)

Gina likes the fact that SBARR, as a communication tool, covers everything that is needed for handover. Gina is also aware that if she has not followed through on the steps correctly, the ACM will ask her to go back to the beginning. She acknowledged that she needs to follow the process correctly. Gina also recalled what it was like before the SBARR communication tool was introduced:

> *I remember once doing a handover over the phone it was before the SBARR days, all I said to the midwife that answered the phone was hello its Gina I've got a problem and she immediately sort of leapt past all the basic information and she said what is going on and she got straight into it. You know primup (first pregnancy) not making progress and I have a long deceleration to 80 beats we are coming in. Right, see you when you get here. And because nothing else really mattered, she could tell from that conversation we had to go. That doesn't happen very often. I think we bypassed something like SBARR, but they also got the message that it's very urgent here.* (Gina)

Gina could get the message across to the midwife on the end of the phone that she had an urgent problem, and the basic information was not important. The midwife wanted to get straight to the point of what the situation was and understood that the LMC needed to get the transfer underway as quickly as she could. What Gina has highlighted is that at the time of the emergency transfer, it is the assessment of the situation that is important not all the other information that can be given later.

The midwives have all commended the use of SBARR communication tool as an improvement in the handover of care information, and support the use of the tool. The use of the tool has brought uniformity to the conversations and the LMC midwives finds this reduces their stress. Blom et al. (2015) concluded that the SBAR model is considered a good structure for effective communication and enhanced patient safety so long as there was a will to change and improve communication but there also

needed to be mutual respect amongst all the team. Following implementation of the SBAR communication tool into their obstetric department, Ting, Peng, Lin, and Hsiao (2017) concluded that the teamwork and safety climate, job satisfaction, and working conditions had improved and the SBAR tool did facilitate good communication amongst the team. What the data shows is that the midwives, both LMC, and core, all feel that like other studies have shown, the introduction of the SBARR tool in their work environment has improved communication and the process of handover.

The Impact of Handover for all the Midwives

The impact of the handovers on the staff midwives was raised by the midwives that worked in the facility and the LMC midwives. Reiger and Lane (2013) have acknowledged that midwifery work in the hospitals has already intensified over the years a result of rising birth rates and increased medical interventions that reflect increasing health problems in pregnant women. Beth talked about life as a senior midwife in a busy unit and the impact of the handovers on their workload:

> *You have a certain amount of staff on during a shift, and you try to keep one person free as a floating midwife. She can give meal breaks to those who are on and she is also able to be back-up for anything that happens unexpected. You then have a woman who arrives in an ambulance who is bleeding, she is labouring, and the woman is from out of town. We do have a lot of scenarios like that. So, you always try if you can, obviously to have someone as backup person for these cases. Some shifts you will start where every single staff member that is available to you is in a room caring for a woman, for example woman having an epidural, oxytocin and you've got nobody - there is just me. You are just flying blind. So, when the LMC requests an epidural, they will go to the co-ordinator and if the co-ordinator is able to provide a core midwife to take over care then she would provide that but there is never a guarantee because of the high workload.* (Beth)

As hospital midwives, Beth says they try to be organised and have an extra midwife available for backup, meal relief, and emergencies. However, in saying that, there are regular scenarios where a handover is required, and she has no midwife available. This may be due to the workload in the unit committing all the oncoming shift to taking midwifery care handover from their colleagues. Beth's only option is to then provide the ongoing care herself, as well as carrying the phone for other emergency transfers.

Cindy talked about the handover from a core midwife's perspective:

> *And if they hand over of course it now becomes the work of the core midwife, well it is much more work for the core midwife, there is not enough of us, while these women wait. So, what happens is that we can only do what we can do and these women who are desperate for pain relief cannot get it because there is not a midwife to look after them and their LMC midwife is in the tea room complaining that it is not good enough that her woman cannot get an epidural and why is this not happening, and they moan that we are not doing a good enough job. That kind of thing simmers along all the time and it is really difficult sometimes.* (Cindy)

Cindy is aware that it is the woman caught up in the situation of not being able to get the pain relief she wants or needs, and as Cindy acknowledged, there just are not enough midwives available to take all the handovers. What Cindy does not find helpful is when the LMC midwife complains about the situation and asks why this is not happening for her woman, when she would have already been told that a core midwife was not available to provide care during an epidural. Cindy finds it difficult when the staff midwives are accused of not doing their job by the LMC midwife. As Beth stated earlier, there is no guarantee of a woman getting an epidural due to the high work load that the staff midwives are already managing. Beth acknowledged it is these situations that can then tension between the LMC midwife and the staff midwife, but she feels these are also misguided:

> *You walk out of the room you have finished caring for a woman, she had an epidural, she might go to a primary unit or she might go to a post-natal ward and then the next woman is waiting and there is just no breathing space. What the feeling is amongst the staff I think, is that some people do become kind of resentful about things because they feel considerably overloaded. That's what gets people tired and grumpy with their LMC colleagues, but it is the wrong direction where their grumpiness goes. It is*

not productive at all. That is not so much of a problem from the perspective of the LMC saying I do not do secondary care, it is the lack of staff from the DHB. (Beth)

Beth's assessment of the situation is that there is just no let up for the core midwife; it is just continual with no opportunity to catch their breath. Beth's awareness extends to the fact that because the staff workload is overloaded, this builds resentment from the core midwife to the LMC midwife, but in fact it has nothing whatsoever to do with the LMC midwife. It all comes down to the staffing levels in the facility. However, Beth also acknowledged that this type of behaviour from the staff midwives benefits no one.

From Kate's (core midwife) experience, precise information from the LMC midwife around the emergency is what informs the next action:

> *Sometimes the experience of the LMC midwife influences how the handover process goes, and this is also to do with the resources of the DHB. I have to access the urgency, if I do not have a midwife who can actually meet them immediately - when they come through - I just do not have that flexibility you know, it then depends on the information I have got from the midwife in the community. If you get precise communication in terms of what has been happening during the labour and you can then get the sense of urgency of the situation and I base the handover on that. I think using the SBARR tool is really helpful in the case of an emergency.* (Kate)

Kate finds at times there is just not enough staff available to manage every handover. Kate must assess the situation and she bases her decision making on the information she has been given by the LMC regarding the urgency of the situation. This is where the experience of the midwife giving the information to Kate is important. Not all handovers can happen immediately and for Kate it comes down to prioritisation. This could explain what Emily (LMC) encounters at handover:

> *I just find that depending on the staff that are available, there may be an issue with midwifery staffing that tends to be the hold up and there are certain personalities where it is almost perceived as a favour for us.* (Emily)

Emily finds that it is usually the availability of a staff midwife that delays the handover for her; and then when the handover does happen the staff taking the

handover make it seem like they are doing Emily a favour and not recognising her right to handover.

Gina (LMC) gave an explanation as to why she hands over the woman for care:

> *Neither of us will ever do epidurals and syntocinon and my philosophy on that is (a) I do not want to and (b) I do not do them as I wouldn't do them often enough. I know last year I had four women have epidurals that weren't having Caesars or other things that is not enough for me to be safe.* (Gina)

As Gina points out, it is not only about her philosophy, it is also about being safe enough to provide the care; hence neither Gina nor her midwife partner provides epidural care. They do not feel confident in providing epidurals when it is a skill that is only used four times a year, and this could then impact the safety of the woman. Calvert et al, (2016) stated that midwives worked to ensure that they had the knowledge and skills required to support the roles they had chosen. Rural midwives know the environment they work in and this impacts the care and decisions they make. There would be many midwives in the same situation as Gina and her partner, that do not do enough epidurals to feel safe to provide the care when the woman requests one for pain relief, or if it has been recommended that the woman have an epidural. This puts pressure on staff midwives to provide the care but, as Gina goes on to explain, she then stays to support the staff midwife and the woman. At the interface of the midwifery care handover, the first thing Gina does is make it clear what her role is:

> *The first thing that happens for me when the midwife arrives, I tell her that I am staying and that I am going to be there as support. I try to make it very clear to them, and it has had really good effect, that they are going to be in charge and that I will do whatever they would like me to do, I am there in a support role, but I am also a midwife and if they need me to do something then I am more than happy to do it. They do need to tell me, cause, I am not just going to do something that they haven't asked me to do.* (Gina)

Gina is fully aware of the pressure on the staff:

> *The most important thing to happen is that there is a midwife available and that is my biggest problem, and that is an ongoing issue, and it is always going to be an ongoing issue with the staffing as it is.* (Gina)

Gina wants to have that midwife available to her at the time of handover, and knows that this is the biggest problem at that time. However, she is realistic when she says she knows it is going to be an ongoing issue until the staffing situation is remedied. Given this realisation, Gina tries to work with the staff and has found that due to the pressure on the staff, sometimes they will shift their boundaries as Gina has found this works:

> *Others (staff) will go, "I'm just here to run the epidural and syntocinon you carry on" and be a bit naughty because they are not supposed to, they are supposed to be in charge. Generally, I find if I make it really clear what my official role is, then most of the time we work really well together, and we make a really good team, and we end up with a really good outcome. Also, they use me to get to know the woman and they will direct some of their questions to me rather than asking the woman.* (Gina)

What Gina has raised is a partnership between the two midwives. There is a busy core midwife and a willing LMC midwife who stays on to support the woman, so is it wrong of them to work in this model? The woman knows the LMC midwife and the staff midwife uses this knowledge to get to know the woman. The focus in this scenario is on the woman and by working in a supportive role the LMC supports both the woman and her midwifery colleague. While this can be commendable of Gina, the NZCOM (2008) *Transfer Guidelines* state following the transfer of midwifery care, the LMC is no longer responsible for providing midwifery care, and stipulates that that the LMC leaves the facility, as the woman is now under the care of the core midwifery staff. There are arguments for and against the LMC staying, and there needs to be effective communication and clear documentation around who is responsible and providing the midwifery care to ensure the safety of the woman and to avoid any confusion or blurred boundaries.

As Cindy (core midwife) concluded:

> *So, we still have the difficulty of the handover of care, and I have to bite my tongue sometimes. The majority of LMC midwives here do not do oxytocin and epidural, and if they do, the staff goes; oh my word that is unusual. So, they have all opted out and some would say that is through laziness, that gets thrown at them and some would say it is to do with philosophy and others would say it's to do with funding.* (Cindy)

Regardless of the reason for midwifery care handover, as Cindy says, it is still difficult to manage the handover and she finds it easier just to bite her tongue and try and do what is expected of her. The core midwives are caught up in the midwifery care handover debate and midwives like Cindy are not interested in the reasons why. The biggest impact for her is having staff able to provide the care. Fergusson, Smythe & McAra-Couper (2010) acknowledge that it is the unpredictability of the delivery suite workload that presents the challenges. No matter how competent the midwives are, when there is not enough staff to take the handovers, it then makes it difficult to maintain safe care. They have no way to predict the workload in terms of numbers or complexity for any given shift.

Beth (core midwife) expressed concern for the LMC when there is no core midwife available to take the handover from the LMCs:

> *So, the LMCs get into this situation where they care for woman for far too long, they are tired and then they cannot handover to the core midwife staff, because there is no one available to handover to. That is another friction point for the LMCs probably because they cannot handover and they are not safe anymore, that's not good. The woman is dependent on the care, she is wanting an epidural, the LMC is not certificated to provide the epidural care, and that sometimes gets lost in that discussion, because then it becomes about the people who provide the care instead of the woman who needs the care, but she needs to remain as our focus at all times, we should be able to make the wisest decision for that particular woman and then the rest needs to work around it.* (Beth)

Beth is aware of the dilemma that gets created when a LMC midwife has already spent a long time with the woman; the woman now needs an epidural and there is no core midwife available to take the handover at that point in time. The woman must wait for the epidural and the midwife must wait to handover the care. Beth can appreciate the frustration for both the woman and the tired LMC and realises the focus then becomes that of the midwives rather than keeping the focus on what is best for the woman. It is a dilemma. As Beth has pointed out the LMC midwife, by this time, is very tired and this puts the safety of everyone in the spotlight. This situation is not one that can be easily managed by the core midwives that need to take the handover, but it is an important one as the impact on both midwives and the woman is a crucial. This very situation highlights the need for the maternity facility

to have enough core midwives available to support the LMC midwives and provide safe care for the woman at the interface of midwifery care handover.

Summary

Midwifery care handover is an ongoing issue for all midwives. While there have been some improvements around processes such as the development of the role of the ACM and the introduction of SBARR, there are other factors that can be an issue for the midwives. All the midwives in this study highlighted issues around the availability of the core midwives to take the midwifery care handover in a timely manner, and the frustration for the LMC midwife who wants to handover, but there is no core midwife available to take the handover. On the other hand, there is the dilemma for the core midwife who is aware that the LMC midwife needs to handover, the woman needs an intervention, and everything gets delayed, until she can take the handover. These factors all have an influence on the interface of midwifery care handover. Gilkison et al. (2017) stated that the impact of core midwifery shortages can lead to less than ideal standards, which then have the potential to affect the quality and safety of maternity services for women.

Chapter Seven: Discussion

The aim of this qualitative study using Appreciative Inquiry methodology was to find out from the midwives themselves what they thought worked well at the interface of midwifery care handover. The use of AI does not exclude the midwives relating their negative experiences; instead, it enables the midwives to reflect and focus on the positive aspects they have experienced at the interface of midwifery care handover. Petersen et al. (2013) found there are numerous authors that identify the negative consequences of inadequate handovers; however, there is little research to identify best practice. Having a focus on the positive experiences then gives a basis on which positive change can be built. This final chapter discusses findings that the midwives have articulated that are important to them, what they consider enablers of the process, and how they impact at the interface of midwifery care handover. These are the things midwives identified about the interface of midwifery care handover.

- The value of professional relationships
- Communication, communication tools and unhelpful communication
- Working in collaboration
- Rural Midwives and their issues around midwifery care handover.
- Midwives coming into the DHB and new graduates
- Associate Charge Midwife role
- Impact of handover for all midwives

Relationships

> *Relationships have been shown repeatedly to be at the heart of midwifery, yet models of care supported by health policy continue to be at odds with the centrality of this element.* (Crowther et al., 2016, p. 47)

Another tension that impacts on handover is the ongoing debate within the profession about primary and secondary care of the woman. The Guidelines for Consultation with Obstetric and Related Medical services (Referral Guidelines) were introduced by the Ministry of Health (2007) and updated in 2012, with the purpose to promote and support coordination of care across providers. However, there are still midwives that say the boundaries between primary care and secondary

care are blurred. Primary midwifery care is the care that a LMC midwife provides to the woman and does not require a medical intervention. Rather than it being a primary/secondary debate, it is more around the services the LMC midwife has chosen to provide to the woman; for example, epidural in labour, syntocinon augmentation. The LMC midwife declares these choices of practice in her Maternity Services, Section 88 (2007) Access Agreement she has with the facility.

One midwife in this study described the pillar of a good handover being respect, trust and communication, and that all three elements needed to be there, as if any part was missing the handover could easily fail. This same notion is supported by a study looking at relationships in maternity care by Hunter, Berg, Lundgren, Olasfsdottir and Kirkham (2008) where they established that relationships are fundamental to effective team working; therefore, they are essential to safe practice, with the key factor being trust. The later study by Crowther et al., (2017) reinforces the ideology, that it is the sound collegial relationships that are essential for safe midwifery care especially when dealing with consultation and handover of care. This same study spoke about the importance of getting to know one another and having the trust there which supported the findings in the current study.

The midwives in the current study acknowledged the importance of establishing midwifery relationships and how these relationships influenced the process of midwifery care handover. The findings revealed that midwives who had established relationships with their midwifery colleagues found the interface of midwifery care handover went well and there was a smooth pathway for the midwife and the woman. This contrasted with the LMC midwife whose experience did not go well, she felt that this was due to the lack of a professional relationship with the core midwife, in fact the LMC midwife was left feeling discouraged and unsupported at the interface of midwifery care handover.

Crowther et al., (2016) stated that relationships have been shown repeatedly to be at the heart of midwifery, "yet models of care supported by health policy continue to be at odds with the centrality of this element". (p. 47). What Crowther et al. has raised supports the findings of this study. The midwives all acknowledged the importance of those professional relationships with their midwifery colleagues, but it was often the midwifery care handover processes that got in the way. The handover of the woman's

care is accepted by the obstetric team and an assumption is made that the core midwife will provide midwifery care. The LMC has a voice in the handover process but the core midwife does not. The exclusion of any reference to core midwives within the referral guidelines results in feelings of disempowerment and tension evident from findings in this study. However, core midwives have been acknowledged by Gilkison et al., (2017) as being the backbone of New Zealand maternity services. It's therefore not surprising that Dixon et al., (2017) concluded in their study that the core midwives reported lower levels of autonomy, empowerment and professional recognition compared to their LMC colleagues. There is a need for midwives to move forward and embrace the work that all midwives do. Midwives need to feel valued for the work that they do, only then can there be a level platform for all midwives to build and establish those important midwifery relationships, which they spoke about in the interviews. The midwives spoke how trust and respect underpin their relationships, and the importance of these elements to build the relationships that will ensure a positive experience at the interface of midwifery care handover.

Communication

What was demonstrated in this study is that there was a link for the midwives between communication and the relationships. From the data, there was the belief that good communication can only happen if there is trust and respect between the midwives, which then supports the relationships between the midwives. The Midwifery Council Code of Conduct (2010) has clear expectations around the inter-professional relationships in that communication needs to be appropriate and respectful. The LMC midwives spoke about feeling validated when the core midwives listened to them. The assessment information they handed over to the core midwife had been accepted without question. This demonstrates the link between communication and relationships that the midwives referred to. The core midwives on the other hand, advocated for timely and clear communication so they could respond accordingly to the handover information.

 Midwives are story tellers, they use stories to explain and justify opinions and actions and to make sense of the complexity of practice (Skinner and Maude,2016). Gould (2017) positions this story telling as midwifery being an oral culture where the knowledge occurs through storytelling. There is the

acknowledgement that midwives are great story tellers; however, the core midwives in this study did not find the story telling useful at the time of handover of midwifery care. It was for this reason they supported the use of a concise communication tool. The literature tells us the importance of effective communication at handover to reduce risk (Berridge, et al., 2010, Borrelli, et al., 2016, Hastie & Fahy, 2010, Petersen, et al, 2013). While the story is important, there is a time, such as handover between primary and secondary services, where the story needs to be left aside and a systematic approach is used to convey the information.

Communication Tool-SBARR

SBARR had been introduced as a communication tool in the workplace of the midwives participating in this study. SBAR is an acronym for Situation, Background, Assessment, and Recommendation but in numerous health care settings they have added an extra R for Response (SBARR). The midwives, LMC and core, all referred to this communication tool and how it had improved communication, but as one midwife said it was not so much SBARR as it could have been another communication tool, it's the fact that they have a process to follow and communication had improved following the introduction of the tool. It had stopped the story telling that midwives like to do. The midwives in this study spoke about the value of having firstly a calm and skilled senior midwife on the end of the phone, and secondly, knowing the acronym would provide the information that was important at the time of handover, especially if it was an emergency transfer in from the community. The core midwives in this study endorsed the use of the communication tool as it would keep both midwives informed of correct details and they could be prepared for the arrival of the ambulance. An example was given when one midwife had an emergency and said, "I didn't use the tool, but they knew what I needed" however on reflection she had in fact used the tool she just had not consciously gone through each of the components. Beckett and Kipnis (2009) also found with their evaluation study of SBAR in a maternity setting, that there were significant statistical changes in the teamwork, communication, and safety climate with the use of the tool. The data from this study suggests that SBARR has supported the midwives and is relevant for these midwives at the time of handover. From their experience, it does work well at the interface of midwifery care handover as a

standardised communication tool. While the midwives extolled the use of SBARR at the time of midwifery care handover, the issue of unhelpful communication was also raised.

Unsupportive Communication

At times communication can be unhelpful. This was raised in the context of how the relationships that have been built amongst midwives can be undermined, by what they described as judgemental and challenging conversations. The communication that midwives did not feel was useful was the judgemental comments made by medical doctors about their midwifery colleagues. Midwives were being judged by the medics and this made the core midwives uncomfortable. It was not appreciated when the obstetric team labelled some midwives as 'good' because they were seen to cooperate with the obstetric team's model of care or, on the other hand, there was an attitude of mistrust towards a midwife. Skinner and Maude (2016) found that midwives who had developed positive relationships with obstetricians were given more autonomy in their decision making. Their findings could explain why some midwives are seen by the obstetric team to 'cooperate' with their model of care.

While the midwives are building relationships to improve the interface at midwifery care handover there was an example of a core midwife cringing because of the way the registrar was speaking to her LMC colleague. The core midwife felt that this was unprofessional, unfair and this behaviour needs to change. There was an inference from an obstetrician who provided locum cover in various areas, that midwifery care handover was only happening in their work place and nowhere else. These comments came across as a challenge to the core midwives that they were 'allowing it to happen' and by doing so were creating an increased workload for themselves. It is these conversations that fuel the angst of midwives and undermine the professional relationships. When these types of uninformed comments are made they have the potential to cause tension amongst the core midwives that already felt like they are working at capacity. Having the core midwives in this study raise this issue, and recognise that there was the potential of other maternity providers to undermine or erode the relationships, demonstrates the value those core midwives place on their relationships with their LMC colleagues. For midwives to have a positive experience at the

interface of midwifery care handover there needs to be collegial support of one another.

Collaboration

Midwifery care handover requires collaboration, and this can only be achieved if relationships have been established. Never is there a more important time for collaboration than at the interface of midwifery care handover, especially when the woman crosses over from primary care to secondary care. The midwives in this study felt that to work in collaboration requires appreciation and understanding of each other's journey prior to the interface. Beasley et al. (2012) stated that in maternity care there needs to be collaboration to facilitate communication, and trust that enables health professionals to provide safe, woman-centred care. As to be expected the reasons for not collaborating include distrust, lack of respect, differing philosophies and negative communication. Midwives have come to expect negativity from other maternity providers, but the reality is, this same behaviour can come from their midwifery colleagues. This then undermines another midwife and therefore has a negative impact at the interface of midwifery care handover. The Midwifery Council, Code of Conduct, 2010 2.2 page 5, states "that midwives interact with their colleagues in a fair and respectful manner", but even in this study there was comments made that do not demonstrate the behaviour of a professional midwife.

The impact of the midwifery care handover debate was raised as an area of tension between the midwives. Midwifery in New Zealand is not about one size fits all, it is about choices that a midwife makes and acceptance by the wider midwifery community around those choices she has made. Calvert et al., (2016) talk about professional positioning whereby the midwife herself creates her personal midwifery identity and determines the level of practice that is acceptable to her.

Rural Midwives

Rural midwives have their own particular issues around the interface of midwifery care handover, and that comes down to acceptance by the core midwives and the medical team of the unique circumstances that the rural midwives work in. In addition to the distances between the base hospital and the rural community practice, there is the consideration of the midwife being able to

return to her community, and covering the local community birthing centre. Crowther (2016) described the plight of the midwives in rural areas, which were the same as the rural LMC midwives in this study. The midwife may go with the woman when they are transferring to a secondary or tertiary hospital, however they can stay or return in the ambulance to avoid being stranded. Whether she stays, or returns can also be dictated by their employment conditions. The rural midwives in this study spoke about 'getting home again' as a big consideration for them, and for one rural LMC midwife this was a priority as she was also contracted to provide midwifery care at the local birthing centre.

For the rural midwives, it is about getting the woman to a place of safety and managing the situation the best she can. As one of the core midwives in this study pointed out these rural LMC midwives are often working in less than ideal situations, with no cell phone coverage and long distances to travel. It is these situations that are not often appreciated by their urban counterparts or the medical team that have had no experience of working in isolation in the rural community.

Crowther, Smythe & Spence (2017) explained that whatever a rural midwife does or does not do in the moment of practice, she fears that someone will stand in judgement if anything goes wrong. Crowther et al, (2017) go on to say that those from the 'urban' world often do not understand the difficulties rural midwives face, nor do they know how hard it is to do the best you can and how helpless rural midwives felt when they cannot do more.

These tensions have an impact on the interface of midwifery care handover as it requires understanding and appreciation of how their realities are very different to their urban colleagues. While some core midwives criticised their rural colleagues, others core midwives celebrated handover as an opportunity to support women who then went on to have a normal birth. What would be even more celebratory, are all midwives being supportive at the interface of midwifery care handover.

Midwives Coming into the DHB and New Graduates

Support for midwives coming into work at the DHB and the new graduates were raised by the core midwives. They felt that newer LMC midwives needed additional support and understanding. The core midwives recognised they are

very familiar with 'how things' are done, whereas the LMCs may not be. Nevertheless, there is an underlying expectation by the DHB staff that all midwives know processes and procedures common to the unit.

Relationships for the new graduate midwife, especially at the interface of midwifery care handover are particularly important. It was felt that the new graduate LMC may be looking for guidance or support with their decision making and the experienced core midwife needs to recognise this and not create barriers for the handover. There were no new graduate midwife participants involved in this study; however, it is noteworthy that working with new graduate midwives was raised by the core midwives. Even more notable was the way it was raised, with a caring attitude and having a sense of responsibility to ensure there were no barriers for the new graduates LMC midwives transferring in, or at the interface of midwifery care handover. The core midwives spoke about leading by example with communication at handover, by demonstrating respect when asking questions and being aware of their own body language when they were with a new graduate or taking a call from one.

Kensington et al., (2016) identified that the graduates received support from all midwives, whether they be core midwives or LMC midwives, mentors or midwifery managers and that there was overt willingness within the midwifery profession to support the new graduate midwives.

Apart from the value of the midwifery relationships at the interface of midwifery care handover there was recognition by the midwives that there were some processes that had recently been introduced into their work environment that had a positive flow on for them.

Associate Charge Midwife Role

The role of associate charge midwife was put in place in some of the DHBs following recommendations to the wider maternity services from the coroner the report on the Nathan case was released in January 2015. DHBs around the country have used coroner Evan's findings in a positive manner with changes made around their transfer policies, with some DHBs working collaboratively to create a regional transfer policy. The purpose of the Associate Charge Midwife role is to take the telephone calls and coordinate the transfers in from primary units and from the secondary care units in the region. In addition to this they also

managed the midwifery care handovers in the delivery suite. In general, the role of the Associate Charge Midwife was spoken of in a positive light with the LMC midwives celebrating them, now only having to make one call at the time of transfer instead of three or four. The core midwives found this role to be practical in their environment, as there was one person coordinating the transfers in and the handovers of care. The LMC midwives also spoke about having a confident senior midwife on the end of the phone which they found to be calming and supportive. There was only one LMC midwife that found it depended on who was on the end of the phone as to whether the process was efficient. Generally, the transfer process worked well with the new system of having an associate charge midwife. The role of the associate charge midwife is one of directing and facilitating to get organised in preparation for the handover or transfer in, with the safety of the woman and the baby being paramount always. I suspect that these associate charge midwives have been put into these roles as they are able to be the 'port in the storm' and somehow manage to remain professional and reassuring to the midwife on the end of the phone or during the face to face interface of midwifery care handover.

Impact of Handover for all Midwives

From the LMC midwives' perspective the inability to handover in a timely manner due to lack of core midwifery staff was a problem. The unpredictability of the delivery suite workload status makes it difficult to staff along with the unpredictability of the needs of each individual woman in labour. Fergusson et al. (2010) stated that the challenge in delivery suite is the unpredictability of the workload, and even the most competent midwives are unable to maintain safe care when there is not enough staff available. It is the lack of staff that would be one of the biggest frustrations for the LMC that is ready to handover and for the core midwife that is aware of the need for a handover but not able to take it.

This same frustration is apparently current everywhere in the country and this issue needs further consideration from the managers that set the base line staff rosters in the country. Scott (2017) asked the question in 2016 about the working life of the midwives in New Zealand secondary and tertiary centres, and has asked again in 2017 if anything has changed. What she found is that nothing has changed; in fact, the situation has deteriorated with a lot of the core midwives

feeling unsafe. The feedback from the core midwives is that there is increasing acuity, sicker women, and an increase in caesareans and inductions of labour. (Scott 2017) They acknowledge their clinical managers listen to them, but it is getting the message further up the management ladder. The current practice in some places is to have an on-call system for the core midwifery staff to be available for the handovers but the question needs to be asked- is this system really working? Scott (2017) reported that midwives are getting tired, goodwill is wearing thin and over the last five years the workload has increased markedly. The hospital staff situation does have an impact on the interface of midwifery care handover and is a big factor when the relationship between the core and LMC midwives break down. It is not the fault of the core midwife in the clinical workplace, but it is often the core midwife that takes the brunt of the frustration when a midwifery care handover is either delayed or at times cannot be undertaken. Therefore, it is important for us to know what works well at handover, so we foster circumstances that support midwives and women at the time of handover.

Limitations of the Study

The limitations of the study are firstly, that it is only a small qualitative study with seven midwives interviewed and secondly, the focus was on one region in New Zealand. However, in acknowledging the limitations, personal experience and conversations at a national level would indicate it is the same issues around the country. The other area that this study did not focus on in depth was how the midwives viewed each other's roles and what was the expectations of each other at the interface of midwifery care handover.

Implication for Midwifery Education

There is the opportunity for the organisations that provide the midwifery training to place an emphasis on the value of professional midwifery relationships and how these relationships impact on the interface of midwifery care handover.

- Further education on the value of the professional midwifery relationship at the interface of midwifery care handover.

- Handover technique- additional education in the use of concise succinct information at the interface of midwifery care handover.

Implications for DHBs

Evaluation of the current core midwifery staffing levels in delivery suite is a priority as it is the lack of core staff available to facilitate the handover of care that has one of the biggest impacts on the working midwifery relationships and increases the risk for the woman and their babies.

- Review Staffing levels in the delivery suites where handovers are taking place. Practices have changed regarding the number of woman requiring one on one care by the core midwives.
- The DHB Midwifery Leaders need to be supported with increasing baseline full time equivalent (fte) to match the workload.
- Midwifery staffing levels must be set at levels that support a 24-hour seven day a week service as per Midwifery Employee Representation and Advisory Service (MERAS) recommendations.
- There is acknowledgement of the work undertaken by Safe Staffing Healthy Workplaces Unit, Midwifery sector but this does not address the immediate issues around the staffing levels.
- Support the recommendation from the MERAS that professional midwifery leadership roles are established and supported in the DHBs. (Mcllhone, Conroy, & Scott 2017).

There is a lot of work to do in the workforce area and it needs to be done to support the midwives at the interface of midwifery care handover. The DHBs, the Unions and the midwives need to work together and recognise the maternity service for its uniqueness and what resources are needed to support the midwives to provide the service. Midwives are there for the women, and if there are not enough core midwives to take the midwifery care handover in delivery suite this will compromise safety for the women.

Implications for Midwifery Practice

The aim of this research was to get an understanding of what works well at the interface of midwifery care handover from the midwives that participated in the study. What the midwives did identify in this study was that the factors that did work well for them at the interface of midwifery care handover was the establishing of professional midwifery relationships, effective communication and working collaboratively together.

Education informs practice and the findings from this study demonstrate there is a need for more education to the community and other health practitioners to strengthen the understanding of what a midwife does and the necessity of effective and concise communication at handover.

- Education incorporating all maternity providers, health practitioners and the wider community on the many faces of a midwife.

This would then acknowledge and support every midwife regardless of where or how she works, and by doing this it would give confidence to the midwifery workforce and support processes such as the interface of midwifery care handover.

- Education on rural midwifery- understanding the roles.

This is still an area of midwifery practice not fully understood or appreciated by everyone in the maternity service. A better understanding of their roles would then improve the relationships between urban and rural midwives which will then support the midwives at the interface of midwifery care handover. This needs to be part of the education around all midwifery roles at the interface at midwifery care handover.

Communication and Communication Tools

This study has demonstrated the value that the LMC and core midwives have put on the use of a communication tool such as SBARR in supporting the midwifery care handover process. The tool enables clear and relevant communication about the situation in preparation for handover. An equally important part of handover is ensuring that a senior midwife who is skilled in remaining calm and systematic undertakes the triage of transfers into the obstetric unit.

This simple to use communication tool or one that is similar could be introduced into all the maternity units once there has been education to everyone around

how to use the tool correctly. The current research available on the use of SBAR or SBARR has all signalled the effectiveness of education prior to implementation. For those units that have already implemented a communication tool, the question is have they audited its use for effectiveness to identify where any gaps may be in their handover communication.

Future research

The aim of this study was what works well at the interface of midwifery care handover. There are still areas of midwifery that are not understood by all the midwives. There seems to be reluctance by some midwives to keep up with the changing face and pace of midwifery. Guilliland and Pairman (2010) understood that the interface between core and LMC midwives was integrated and the environment provided support for both. If this was the case, there would not have been the need for this study. Recommendations for further study would be looking at how midwives view each other's roles to gain further appreciation of where and why there can be a breakdown at the interface of midwifery care handover, but more than that, to gain an understanding of what barriers there are between the LMC and core midwives.

Conclusion

This study has demonstrated that midwives need to build professional relationships that will support the interface of midwifery care handover and this can only be achieved through the values of respect and trust for each other. If these elements are there then it follows that the communication will be appropriate and supportive between the midwives at the interface of midwifery care handover. Acknowledgment of the roles that all midwives have (Core and LMC) in the woman's journey when there is a transition from primary to secondary midwifery care, and by collaborating and working as a team, this will ensure the woman is kept safe following midwifery care handover. The processes such as having one contact person and the use of a communication tool are beneficial. By having an appreciation of what the midwives in this study thought worked well at the interface of midwifery care handover, this information can be shared and provide guidance for midwives to build on their interface at midwifery care handover. If the midwifery profession can get this right, risk to the woman will be reduced. Midwives are in the business of

providing safe care to the woman and any improvements to practice issues can only be seen as being beneficial.

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4.3 Process for transfer of clinical responsibility for care

Roles and responsibilities

Conditions listed as Transfer are those for which the LMC must recommend transfer of clinical responsibility from the LMC to a specialist. Once clinical responsibility for care is transferred, clinical decisions and decisions on the roles and responsibilities of all other practitioners involved with the woman's care rest with the specialist, taking into account the needs and wishes of the woman.

There is potential for LMCs to retain a role providing care for the woman, especially where the LMC is a midwife. Continuity of care should be preserved wherever possible. For example, where a woman who is pregnant with twins requires specialist oversight but continues to receive antenatal care from her LMC, the specialist has clinical responsibility.

An LMC may decline ongoing involvement with a woman's care if the clinical situation is outside their scope of practice or experience or unreasonably impacts on their workload.

Communication

The critical part of this process is documenting the point at which responsibility for coordination and provision of maternity care is formally transferred from the LMC to the specialist. This requires:

• a three-way conversation between the LMC, the woman and the specialist to determine that the transfer of care is appropriate and acceptable

• the LMC to provide all relevant information, including any relevant maternity notes, test results, and histories, to the specialist

• a discussion and documented decision about the nature of the ongoing role of the LMC or whether all care, including midwifery care, is transferred to the specialist and the DHB midwifery team.

Transfer of clinical responsibility requires timely and full communication from the LMC to the specialist; and then from the specialist back to the LMC. All other practitioners involved in the process (eg, GP or other primary care practitioner) should be informed of the decisions made.

Meeting local conditions

The detail of transfer of care processes will differ depending on the scope of practice and experience of the LMC and others involved in the woman's care. It will also vary according to geographical considerations; some women may be transferred to the care of a specialist in the nearest main centre due to limited options in their local area. A number of district health boards (DHBs) have formalised systems for tracking the transfer process. The steps in Process Map 3 should be reflected in local processes or protocols.

Figure 4: Process Map 3: Transfer of clinical responsibility for care
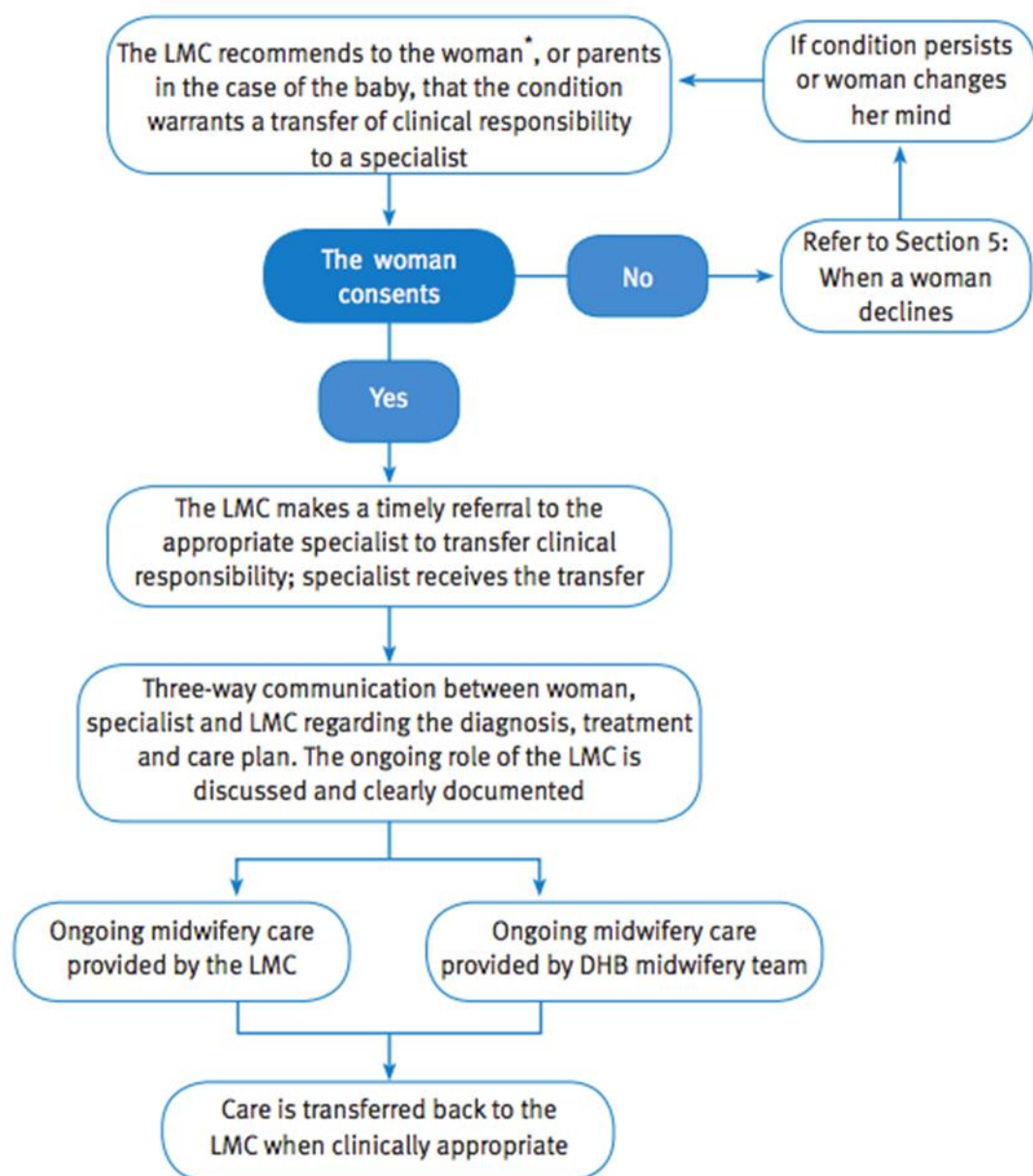
* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

Participant Information Sheet

Date Information Sheet Produced:

January 2016

Project Title

What works well at the interface of midwifery care handover

An Invitation

Tena koutou.

My name is Margret Norris, I am a registered midwife, and I am also a student at AUT University undertaking a Master of Health Science programme.

I would like to invite you to participate in my research study. This study will contribute towards my Masters qualification. Your participation in this study is voluntary and you may withdraw at any time prior to the completion of the data collection.

I am a midwife currently employed by the Bay of Plenty District Health Board as the Midwifery Leader. I have been in this current role for nine years, prior to that I had various midwifery positions including Clinical Midwife Manager, Staff midwife and a self-employed midwife working in a urban/ rural setting.

To avoid any conflict of interest I am undertaking this study outside my own District Health Board region so that there can be no biases in this study.

What is the purpose of this research?

The New Zealand Model of Maternity Care is unique, following the amendment to the New Zealand Nurses Act 1990, when midwives were given back their autonomy. This was further developed in 1995 with the introduction of the Lead Maternity Carer (LMC) concept where the woman has one identified lead person to coordinate their care during pregnancy.
Midwives have the necessary skills to provide care during normal childbirth (primary care). There can be times during pregnancy, labour and postpartum when the woman requires an intervention that is outside the scope of practice of that particular midwife. It is at this point that this midwife needs to consider handover of care to an obstetrician (secondary services), usually this will also include handover to a core midwife who will provide the midwifery care for the woman.

The aim of the study is to look at what works well for midwives at the time of handover of midwifery care.
Knowledge generated from this study will inform midwifery practice, process development and education around the successful handover of midwifery care.

Why am I inviting you to participate in this research?

I am interested in interviewing midwives around their experiences with the handover of care either from another midwife or to another midwife.
Handover from a primary facility to a secondary setting is most frequent, however, on occasions, transfer might occur from a woman's home into a birthing unit or from one District Health Board to another.

Midwives interested in participating in this study can be employed or self-employed, but they must have a current practising certificate and be currently practising as a midwife.

What will happen in this research?

As a midwife willing to participant in this study and meeting the criteria, you will be asked to send your contact information to me.
 Once I have received your contact details, I will then make contact with you to discuss and address any queries you may have around this study.
 If you still wish to participate in the study I will then arrange to have the Consent Form sent to you, once this has been signed and returned to me I will then make contact with you to arrange a place and a time suitable to you for an interview.
The interviews will take approximately 60 minutes, and with your consent they will be digitally audio recorded.

As a reference for you at the interview I will have a copy of this information that you may refer to at any time.
To maintain your confidentiality through this process you will be assigned a pseudonym to conceal your identity. You will also be reminded that you have the right to withdraw from the study prior to the collation of your interview.

This study is about your personal experiences involving the handover of care from one midwife or to another midwife. There are no formal questionnaires or surveys, but I will prompt you with questions to ensure we maintain the focus of our interview on the handover process.

Following the interview, the information will be typed up by a typist that I have engaged to support me in this study. This person has also signed a confidentiality form to ensure everyone is protected in the study.

Once I have received and reviewed the typed transcript this will then be returned to you to ensure the transcript reflects our interview and also to make any changes that you wish to. If the transcript has not been returned in the agreed time frame set by you and I at the time of the interview, I will make contact with you to check if you have any concerns and encourage the return of the transcript.

All information relating to the study will be stored securely for the duration of the study and for ten years from completion date. The information will then be shredded.

What are the discomforts and risks?

While every effort will be made to minimize risks and discomforts by ensuring the interview, date, time and venue is agreeable and conducive to your wellbeing, there can be times when interviews may trigger a recall of an event that you have found distressing in the past.

How will these discomforts and risks be alleviated?

These situations cannot be predicted but an awareness of this by both parties will then be acknowledged and a decision would be made whether to continue with the interview at the time, or come back together at another time or else withdraw.

What are the benefits?

The knowledge that is gained from the interviews will then inform midwifery practice, processes and education around the handover of midwifery care. This may result in a tool that can be used by midwives to ensure that there is minimal risk to the woman at the time of the handover and that the midwives have the confidence in their own practice when giving or receiving a handover from another midwife regardless of the setting.
This study will also contribute towards my thesis for my Masters of Health Science.

How will my privacy be protected?

As previously stated, prior to the commencement of the interview I will ask, you to choose a pseudonym or I can assign you one, to maintain your confidentiality. The interview will be transcribed by a typist that has signed a confidentiality agreement. There will be no identifying information about you or where you work in the thesis, or any article or presentation related to this study. The researcher and her two supervisors will have access to the data during the data collection and analysis stages. All information relating to this study will be stored securely and will be shredded six years following the completion date.

What are the costs of participating in this research?

The cost to you will be in time. The time for the interview, which will be approximately one hour, and then allowing enough time for you to review the transcript after the interview, this maybe up to an hour.
 If I need to come back to you for a second time following the interview I would anticipate it would be another 30 minutes if it was going to be longer I would notify you at the time of contact.
There may be a cost in time spent travelling to the interviews, but it is anticipated that I will come to you at an agreed time and place.

How do I agree to participate in this research?

If you are interested in participating in the study, please contact me either by the phone number or email address below. I will then make contact with you, provide all the written information that is relevant to the study including a Consent Form, once I have received that we will then have an interview at an agreed date, time and place.

Will I receive feedback on the results of this research?

A summary of the study findings will be offered to all participants at the completion of the study. The completed thesis will also be available to any interested party through AUT University.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Judith McAra-Couper, judith.mcara@aut.ac.nz Phone: 09 921 9999 ext.7193.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Margret Norris. margret.norris@bopdhb.govt.nz or Cell Phone: 021 791 738

Project Supervisor Contact Details:

Dr Judith McAra-Couper, judith.mcara@aut.ac.nz Phone: 09 921 9999 ext.7193.

Approved by: Auckland University of Technology Ethics Committee on 18 May 2015. AUTEC Reference number 15/82

Consent Form

For use when interviews are involved.

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project title: What works well at the interface of midwifery care handover

Project Supervisor: Dr. Judith McAra-Couper

Researcher: Margret Norris

○ I have read and understood the information provided about this research project in the Information Sheet dated January 2016.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one): Yes○   No○

Participant's signature: ....…………………………………

Participant's name: ....…………………………………

Participant's Contact Details (if appropriate):

…………………………………………………………………………………..

………………………………………………………………………………….

Date:

***Approved by the AucklandUniversity of Technology Ethics Committee on** type the date on which the final approval was granted **AUTEC Reference number** type the AUTEC reference number*

Note: The Participant should retain a copy of this form.

Appendix D: Ethics Approval

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

18 May 2015

JudithMcAra-Couper
Faculty of Health and Environmental Sciences

Dear Judith

Re Ethics Application: **15/82What works well at the interface of midwifery care handover?**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Subcommittee (AUTEC).

Your ethics application has been approved for three years until 18 May 2018.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online throughhttp://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 18 May 2018;

- A brief report on the status of the project using form EA3, which is available online throughhttp://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 18 May 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Margret Norrismargret.norris@bopdhb.govt.nz

Advertisement sent to the New Zealand College of Midwives Regional Secretary, following approval from Lesley Dixon, Midwifery Advisor, NZCOM.Christchurch.

Invitation to participate in midwifery research.

What works well at the interface of midwifery handover.

My name is Margret Norris, I am currently employed at the Bay of Plenty DHB and I am also enrolled as a student completing my Masters at AUT. I am interested in hearing from midwives who would like to participate in this research.

- You can be employed or self- employed, but you must be currently practising in the Waikato DHB area or Lakes DHB area.

- I would like to hear your experience regarding handover of midwifery care and what you thought worked well at the time.

If you are interested, please contact me for further information.

Margret Norris: 021 791 738

margret.norris@bopdhb.govt.nz

Appendix F: Typist Confidentiality Agreement

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title   What works well at the interface of midwifery care handover

*Project Supervisor:*Dr Judith McAra-Couper

Researcher: Margret Norris

○   I understand that all the material I will be asked to transcribe is confidential.

○   I understand that the contents of the tapes or recordings can only be discussed with the researchers.

○   I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ....…......................................………

Transcriber's name: ....…......................................………

Transcriber's Contact Details (if appropriate):

…………………………………………………………………………………..

…………………………………………………………………………………..

…………………………………………………………………………………..

…………………………………………………………………………………..

Date:

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on 18/5/2015 AUTEC Reference number 15/82

Note: The Transcriber should retain a copy of this form.

What works well at the interface of Midwifery Care Handover.

<u>*Interview Questions.*</u>

- Background/demographic question.
  Tell me about your midwifery background and your midwifery journey to date.

- Experience of handover.
  This study is about midwifery care handover, could you tell me what your experience is and how it has been for you.

- Opinion
  Given that this study is about what works well at the interface of midwifery care handover, can you tell me about a time when handover worked well.

- Feelings
  How did you feel at the time and what were your main considerations around the handover?

- Dreaming.
  If you could change anything at all for the process of midwifery care handover,