RESEARCH ARTICLES

Single registered midwives contributing care for general patients: a scoping study

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ABSTRACT

Background: Midwifery vacancies persist in small maternity units in Australian rural and private settings where midwives are expected to also care for general (non-maternity) patients when midwifery activity is low. Recruiting dual registered nurse/midwives over single registered midwives is preferred, as single registered midwives are seen as inflexible to assist with nursing work. Little is known about single registered midwives' contribution to care of general patients in small maternity units.

Objective: This scoping study aimed to consult single registered midwives and managers of single registered midwives to determine perspectives on single registered midwives' contribution in small maternity units where the workload encompasses both midwifery and care of general patients, to inform further research.

Study design and methods: This study used a qualitative description design. Two online focus groups were held, one containing three single registered midwives, the other three managers of single registered midwives. Similar questions were posed to each group about single registered midwives' contribution to care in small maternity units. Data analysis was conducted collaboratively through coding and thematic categorisation processes.

Results: Four major categories were found. Single registered midwives' scope of practice concerning general patients is undefined; single registered midwives possess transferrable clinical skills applicable to general patients; practical, professional, and emotional barriers exist for single-registered midwives in small maternity units; and future research recommendations include scope of practice and workplace experiences.

Discussion: Persistent midwifery vacancies are implicated in the closure of small maternity units to the detriment of childbearing families. Understanding the contribution of single registered midwives in small maternity units will inform future research and midwifery recruitment strategies to improve access to services.

Conclusion: The experiences of single registered midwives working in small maternity units warrants further investigation. This scoping study contributes to the literature about single registered midwives' experiences in small maternity units and suggests considerations for future research.

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Implications for research, policy and practice: Findings from this study provide information about the contribution of single registered midwives to small maternity units where there is an expectation to contribute to care of general patients in addition to midwifery. Future research into the experiences of single registered midwives working in these settings will generate information to inform recruitment strategies, potentially improving access to maternity care in small maternity units and may be used in the review of midwifery regulation and educational standards.

What is already known about the topic?
- Midwifery vacancies persist in small maternity units in rural and regional areas where the workload comprises both midwifery and nursing practice, despite strategies to recruit dual registered nurse/midwives.
- Dual registrants face challenges in maintaining both nursing and midwifery professional obligations in small maternity units.
- There are increasing numbers of single registered midwives registering each year in Australia and educational opportunities to become a single registered midwife exist in rural settings.

What this paper adds:
- Single registered midwives make a useful contribution to care in small maternity units, and they assist with the care of general patients.
- The scope of practice for single registered midwives in assisting with general patients is not defined.
- Recommendations for future research include scope of practice for assisting with general patients and workplace challenges faced by single registered midwives because of their midwife-only qualification.

Keywords: midwife; direct-entry; dual-registered; scope; workforce; rural.

OBJECTIVE

The objective of this study was to scope the perceptions of Single Registered Midwives (SRMs) and Managers of SRMs (Managers) on the contribution of SRMs to small maternity units in Australia for the purpose of informing future research and to begin to address a gap in the literature about this topic. Persistent midwifery vacancies have been implicated in the closure of small maternity units, particularly in rural areas, with associated poorer outcomes experienced by childbearing women and babies who live in these communities.[1,2] This study provides guidance for future research to help inform midwifery employment policy, potentially improving access to maternity care in Australian rural and private settings.

BACKGROUND

Prior to the last 20 years in Australia compared to other countries, registered midwives have also been registered nurses, known as "dual registrants". To some degree, this convention was maintained because small maternity units in rural and private hospitals require a flexible workforce: dual registrants may be deployed to midwifery or nursing areas across and sometimes within shifts depending on demand. However, in 2002 the Bachelor of Midwifery was introduced in Australia resulting in midwives registering without also being a registered nurse.[3] The requirement to work across nursing and midwifery areas in small maternity units underpins strategies to discourage employment of midwives who are not also registered nurses (identified as 'Single Registered Midwives' and colloquially known as 'direct entry' midwives). The term 'Single Registered Midwives' chosen for this study may imply something is missing, i.e., registered nurse qualifications. However, it is the holding of midwife qualifications without registered nurse qualifications that underpins the focus of this study and the emerging themes, therefore the term is appropriate.

The requirement for SRMs to also care for general patients raises questions around scope of practice and responsibility for care, inherent in decisions to delegate care of a general patient to a SRM. Delegation decisions between nursing and midwifery are underpinned by the Nursing and Midwifery Board of Australia's [NMBA] Decision-Making Framework (DMF).[4] In small maternity units SRMs assist with general patients within their scope of practice of midwifery, yet defining scope of practice for midwives in caring for general patients is complex as the regulatory approach to scope of practice is flexible to allow for expansion of scope whilst also ensuring safe care.[4]

Despite the implementation of strategies to increase recruitment of dual registrants, midwifery shortages persist in small maternity units in rural and regional areas,[5] and private settings in Australia. For this study, the characteristic of midwives being expected to also care for general (non-maternity) patients during periods of low midwifery activity, was used to define a 'small maternity unit'. Conventional measures to categorise maternity units, such as using bed or birth numbers, or geographical population data as in the

Australian Statistical Geography Standard do not account for small maternity units situated in private hospitals in regional or metropolitan areas, nor do they describe the requirement for midwives to also work in nursing roles.

Concerningly, midwifery shortages have been implicated in the closure of maternity services in Australia in recent decades. Kildea report that between 1992 and 2011, 255 or 41% of all maternity units in Australia closed, and of these, 36 were in Queensland.[1] Similarly, Brown and Dietsch report that 32 maternity units have closed in New South Wales since 1992.[6] Kildea demonstrated a statistically significant correlation between the numbers of maternity unit closures and an increase in babies being born prior to arrival at a maternity service.[1] Women giving birth prior to arrival at a maternity service are at risk of poorer outcomes such as perineal lacerations, and babies are more likely to be admitted to a neonatal unit and to be at increased risk of perinatal mortality.[1,2] In addition, women who are required to relocate away from their community for birth as a result of local maternity unit closures face increased financial pressure and negative psychosocial outcomes.[1,2,7]

LITERATURE REVIEW

Although small maternity units as defined in this study occur in all geographical locations and across health sectors in Australia, literature specific to the midwifery workforce where midwives are required to work in both midwifery and nursing roles is restricted to rural and/or remote areas. Specifically, there is a lack of literature about the experiences of SRMs working in small maternity units and assisting with general patients. Yates explored the experiences of eight dual registered midwives in a small maternity unit in rural Queensland and found dual registrants face challenges in keeping abreast of the professional requirements for both the nursing and midwifery professions.[8] This was also found in a study by Gray about how dual registrants provide evidence for both professions as required by the regulator; [9] and Longman in a study exploring barriers to implementation of maternity reforms in rural and remote areas in New South Wales, Northern Territory, Queensland and Western Australia.[10] Opinion pieces by Yates, Francis and Stewart espouse the benefits of dual registrants over SRMs for work in rural maternity units.[11,12,13] This pervading view is evident in participant responses in the Longman study, as well as in Kruske study about Australian primary maternity units, and Dawson study which considers caseload midwifery for rural areas,[2,10,14] however, the argument lacks depth because the contribution of SRMs working in small maternity units is not considered.

The literature suggests caseload midwifery, a model of care where midwifery workload is mapped to the provision of antenatal, birth and postnatal care for a group of women, is a potential strategy to attract midwives in rural areas.[6] However, availability of caseload midwifery models in Australia is low with around 8% of childbearing women able to access this model of care nationally.[14] Nevertheless, caseload was confirmed as feasible for rural maternity units in a review by Brown and Dietsch, and in an implementation study by Tran.[6,15] However, apart from opinions expressed by some authors, the discussion about caseload midwifery does not specifically include suitability for SRMs.

The literature shows that despite strategies to recruit dual registrants, the problem of midwifery vacancies in small maternity units persists, yet the views of SRMs contributing in this setting are not evident. Based on the background problem and the absence in the literature of the perspectives of SRMs working in small maternity units the research question for this scoping study was: What are the perspectives of Single Registered Midwives and Managers of Single Registered Midwives on the contribution of Single Registered Midwives working in small maternity units?

METHODS

This scoping study was undertaken using a qualitative description design, which is useful for answering a research question where it is necessary to gather information from participants who have experienced the phenomenon in question.[16] Two online focus groups were conducted; one containing three SRMs, the other containing three Managers of SRMs, and each focus group lasted between 40 – 45 minutes. Separate focus groups were convened so participants could speak freely without any risk of influence upon their responses, or for the SRMs, power distance-related inhibition. The focus group questions aimed to elicit SRMs' experiences of midwifery and assisting with general patients, explore the perspectives of SRMs and Managers regarding SRMs' contributions to small maternity units, and to seek recommendations for future research.

ETHICS

Ethical approval was gained from the Edith Cowan University Ethics Committee with the approval number REMS NO: 2020-02079-BULL. Approval from employment sites was not required because this project was about SRMs and Managers experiencing a workplace phenomenon, which may have occurred currently or in the past, and it was not specific to any workplace. Additionally, no information about the specific hospital was recorded in the data. All data gathered have been handled according to National Health and Medical Research Council [NHMRC] requirements.[17]

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PARTICIPANTS

Facebook® and Facebook Messenger® were used for targeted recruitment of SRMs and Managers meeting the criteria of experience working in small maternity units where some general nursing was required. Social media is a successful medium for recruitment and is cost effective.[18] The participants were from Western Australia, the Northern Territory and Queensland. Three SRMs and three Managers responded to the invitation and all participated. Prior to participation, each participant read the supplied participant information letter, was given the opportunity to ask questions, and returned a signed consent form.

The aim of this scoping study was to inform research questions for a future study, therefore a total of six participants was sought. Bradshaw and Kim confirm that small participant numbers are sufficient for qualitative projects where the sample size answers the research question, which occurred in this study.[16,19]

DATA COLLECTION AND ANALYSIS

The principal researcher conducted the focus groups with one other researcher present. The focus groups were recorded, transcribed verbatim, and processed through first and second level coding. A process of thematic analysis as described by Braun and Clark was used to interpret the data.[20 (p 35)] Each researcher was involved in the coding process with discussion leading to agreement on subcategories and categories. First level coding revealed eight subcategories based on the focus group questions (see Box 1).

1. SRMs and Managers of SRMs experiences of SRMs working shift work in a unit where they are required to contribute to care for general patients.
2. How SRMs have contributed to the care of general patients.
3. What participants understand SRMs' scope of practice to be in relation to non-midwifery work.
4. What challenges SRMs face working in a small maternity unit.
5. What participants say the highlights of SRMs working in a small maternity unit are.
6. Ways SRMs' contribution to caring for general patients can be supported or enhanced.
7. What participants say the highest priority issue impacting SRMs' working life is.
8. For the study exploring SRMs work experiences in small maternity units, what participants say the research questions should focus on.

BOX 1. SUBCATEGORIES DERIVED FROM FOCUS GROUP QUESTIONS

The subcategories were condensed to four major categories during second level coding. During analysis, care was taken to ensure the interpretation of the findings remained close to the original description of the phenomenon evident in the participants' responses.[16,19,21]

RESULTS

Four major categories were derived from an analysis of the responses allocated to the eight subcategories. An explanation of the major categories follows.

1. THE SCOPE OF PRACTICE FOR ASSISTING WITH GENERAL NURSING PATIENTS IS NOT DEFINED

There was consensus among participants around the types of tasks SRMs could do to assist with care of general patients and SRMs were willing to assist with general patients but were clear they could not be responsible for the overall care of the patient, yet they felt this is what was being asked of them.

> *…things that fall within midwifery, so that's administering medications, doing observations, doing basic wound dressings* (Manager 3)

> *Checking medication and helping with meal breaks on other wards … answer call bells and obviously do things within my scope such as obs …* (SRM1)

> *I'll look after them under supervision of someone else but I'm not signing care plans or taking that sole responsibility anymore* (SRM1)

> *I'm happy to assist, I'm just not happy to have responsibility for that patient (SRM2)*

> *We're not taking responsibility, we're assisting … we're just assisting, we're not taking the complete responsibility of the patient* (SRM3)

Conversely, Managers were clear the responsibility for the overall care lies with the registered nurse.

> *…and they would be working under the directive of the RN [registered nurse] on the general ward* (Manager 2)

> *…to say, "but you are guided by an RN, you can always ask"* (Manager 1)

Managers acknowledged SRMs were concerned about working outside their scope of practice and experienced resistance from SRMs to assist with care for general patients.

> *I think it's a little bit of a perception risk and overcoming that, "I'm not comfortable because it's not my scope of practice"* (Manager 2)

> *And [SRMs] are quick to say, "that's not my scope of practice" but you can say "well, no, this is your scope of practice, you can do all these things"* (Manager 3)

2. SRMS ARE KNOWN AS SKILLED AND CONFIDENT MIDWIVES WITH TRANSFERRABLE SKILLS TO CARE FOR GENERAL PATIENTS

Managers described the value of SRMs' midwifery practice and that SRMs had a role to play in caring for general patients by virtue of the interchangeable patient care skills they possess from being an educated health professional.

> *…they're a lot more confident maybe, with their midwifery skills in terms of they've had a lot more time just consolidating their midwifery skills whereas a lot of nurses, … they'll work elsewhere, and they'll come and pop in and do a bit of midwifery…therefore they're not as confident with their midwifery skills* (Manager 3)

> *…with our direct entries, they're very passionate and they're fantastic because predominantly that's what we're here for is maternity patients and women and they are very women focussed and centred and it's amazing.* (Manager 1)

> *….then those lectures and things become very multidisciplinary and very interchangeable with those skills in terms of looking after nursing patients* (Manager 2)

Managers highlighted that the specialist knowledge SRMs lack in caring for general patients can be mitigated by consulting with nurses or doctors who have accountability for the patient. In examples provided by SRMs of caring for general patients, these interchangeable skills were evident.

> *…when it comes to more specialist medications, just like anybody, if you're not sure of a drug that you are giving, and the side effects, the interactions, then you need to be speaking to your pharmacist, you need to be speaking to your medical officer and all of those sorts of things so that you get that understanding of what that means if you're not sure* (Manager 2)

> *…specialling a mental health patient, a man who was in ED who was sedated…* (SRM1)

> *she … had been admitted for lower pelvic pain, and I just did basic obs and did her urine dipstick for pregnancy test etcetera, all that sort of thing so actually it gave me a lot more practice in my job than I realise* (SRM3)

SRMs indicated they were comfortable in their role as assistant to the registered nurse in the provision of care:

> *… registered nurse, so they're allocated the general patients but because being the second staff member, any assistance that they need, I am the staff member that's there to assist them* (SRM2)

3. SRMS ENCOUNTER PRACTICAL, PROFESSIONAL, AND EMOTIONAL BARRIERS WHICH IMPACT ON THEIR EXPERIENCES WORKING IN SMALL MATERNITY UNITS

Managers and SRMs acknowledged practical barriers such as SRMs being redeployed to nursing work when midwifery activity is low. SRMs extrapolated this to include working in isolation when their dual registered colleague is redirected to nursing work and feeling compelled to do extra hours to assist their colleagues in times of staff shortages.

> *if the other wards, general ward, or particularly paeds or even ED [emergency department] have a higher acuity than us then my senior staff member, if they are dual registered, being taken to take a patient load on one of those wards which leaves me on my own.* (SRM1)

> *I had a woman come in at 3 o'clock in the morning and birth a baby in the shower half an hour later. So, I was lucky that my afterhours manager [not a midwife] has done obstetric emergency training and she was capable of being the second midwife, she's good with neonatal resus, because my clinical midwife wouldn't have gotten from the other ward in time* (SRM1)

> *… very low staffing levels… constant pressure to do overtime, feeling you're stuck, you can't go home if there's somebody in labour because there just isn't anyone else to call* (SRM2)

Professionally, both SRMs and Managers acknowledged a stigma exists around not being a registered nurse as well as a midwife, and the midwife-only qualification is misunderstood by doctors, nurses and dual registered midwives. These views can lead to resistance from other professions to work with SRMs, disrespectful comments to SRMs, and the need to defend their qualification.

> *…because I'm working with obstetricians it was originally, getting around their perception of those direct entries… and having to dispel those [myths], "oh but she's just a direct entry; oh, I don't know about working with them"* (Manager 1)

> *…definitely felt that stigma and felt belittled a little bit because I was, as they put it, "only going to be a midwife", and I was told straight out, no regional hospital would employ me (SRM1)*

> *The challenge you do face is respect for being just a midwife* (SRM3)

> *I never, ever, ever, not to anybody say, "I'm just a midwife", because we have worked really hard to get where we are* (SRM2)

SRMs identified emotional challenges specific to working in small maternity units. They described feelings of coercion and pressure to work outside their scope of practice in nursing work and feeling unsupported by hospital leaders to roster enough midwives when needed.

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> *…so there's a bit of pressure with some of the … older midwives [dual registrants] saying, you know, "it's easy, there's nothing to do, you can do it" … and I always think, well the problem I have with that is that I don't know what I don't know.* (SRM2)

> *…. under pressure to be on call more so, and it's struggling to get that approved unfortunately, by exec, because they have this wonderful saying that "we can't staff on maybes".* (SRM1)

Compounding these experiences, the Managers reported a pervading "us and them" attitude between SRMs and their dual registered colleagues.

> *on the other side is that my RN, the dual, their main problem is that they do get an us and them attitude because it's like "well I'll have to have all the surgical patients again and you get to have the mid"* (Manager 1)

4. SRMS AND MANAGERS RECOMMENDATIONS FOR FUTURE RESEARCH

Participants concurred that negative experiences encountered by SRMs should be further explored in future research. In addition, SRMs felt the focus group questions used in this study were appropriate to guide future research and Managers were interested in the views of SRMs that would empower them to work more broadly in small maternity units.

> *… they have amazing skills … that can be transferrable and … they're able to work with a registered nurse as well. How to empower them to be able to do that and be confident in that* (Manager 1)

> *… that culture and the terminology around being direct entry midwives and what that means and how that can affect us* (SRM1)

> *… what they think, or what they feel as to how we can get around some of those feelings if there is any negativity, ways of dealing with that* (Manager 1)

DISCUSSION

The findings of this scoping study confirm much of what is anecdotally known about the experiences of SRMs working in small maternity units and identifies areas for further research into this area. The findings show there are misaligned views around SRMs' scope of practice for non-midwifery work. The NMBA defines scope of practice for both midwives and nurses as that which the "profession are educated, competent and authorised to perform" and they acknowledge there is overlap between professions.[4 (p 14)] Commensurate with the NMBA scope of practice definition,[4] this study shows examples of tasks SRMs appropriately carry out when assisting with general patients, however the perceptions of SRMs and Managers are not aligned concerning who takes overall responsibility for the care of the patient. SRMs' responses indicate they believe they are being asked to take responsibility for overall care, yet Managers' responses show they are aware SRMs must provide care to general patients under the supervision of a registered nurse.

The evolving nature of scope of practice has underpinned Australia's approach to governance. By introducing the DMF for nurses and midwives the NBMA provides for care to be carried out flexibly, be appropriately delegated, and scope expanded in a safe and consumer centred way.[4] Although the DMF and other NMBA regulatory documents such as the Midwife Standards for Practice allow for expansion of scope, these documents firmly situate midwifery practice within midwifery, and nursing practice within nursing.[22] Overlapping scope between midwifery and nursing is not prescribed, yet a relevant concern for SRMs caring for general patients is that they want to be sure they are not working outside their scope of practice and they are not being held responsible for care of general patients. This implies SRMs are aware of the ramifications of working outside their scope yet they may lack awareness of the DMF and its purpose to guide decisions about scope of practice and delegation of care between nurses and midwives.[4] Clarity surrounding this anomaly may ensure SRMs feel more comfortable in assisting with care of general patients, which is important because as this study showed, the transferrable care skills SRMs possess are valued by Managers.

In terms of value to a health service, the phenomenon of SRMs assisting with general patients draws comparisons to the role of the Assistant in Nursing (AIN). Duffield explain that AINs are an unregulated workforce, their training and education for the role is inconsistent, and there is evidence for poorer outcomes where an AIN provides care instead of a nurse.[23] It would be useful to see how outcomes compare when SRMs provide care for general patients because midwifery is a regulated profession educated through a nationally accredited higher education course.[24] Duffield explains one of the problems having AINs working in nursing is the lack of a clear strategy for implementation leading to confusion as to how they fit into the scheme of nursing care.[23] This point parallels the SRMs' experience of being expected to contribute to care of general patients. The value to the health service in terms of cost savings of an SRM who is already rostered on the shift, and who can provide care under supervision instead of bringing another nurse onto the shift at an extra cost, needs additional scrutiny because patient safety should never be compromised by having inappropriate staff to provide care.[4]

The perspectives of both SRMs and Managers working in small maternity units revealed SRMs experience significant workplace challenges. SRMs explained that midwifery shortages are a significant problem, concurring with reports of midwifery vacancies in rural areas,[5] and they feel compelled to work extra hours to support their colleagues. Redeployment of dual registrants to nursing work has been revealed by this study to impact SRMs' experiences. Evidence

suggests that when dual registered midwives are redeployed, they miss opportunities to consolidate their midwifery practice leading to loss of confidence to practice midwifery and this point was confirmed by Managers in this study.[8,11,25,26] However, SRMs face a double impact of redeployment. Either the SRMs are redeployed to nursing work and feel concerned about working outside their scope, or their dual registered colleague is redeployed leaving them working in isolation. Examples given by SRMs in this study suggest that the effect of redeployment of dual registrants may result in suboptimal care for maternity patients, a concern identified in the literature.[10,26]

Compounding work stressors for SRMs is the professional stigma they face for not also being a registered nurse. Both groups acknowledged the midwife-only qualification can be misunderstood by doctors and nurses, and SRMs experience verbal challenges to their qualification causing them to feel disrespected in the workplace. Managers also described a division between the dual registered midwives and SRMs, likened to an "us and them" attitude, where the dual registrants felt disadvantaged because the SRMs are always allocated midwifery patients while the dual registrants are allocated general patients. Both concepts of disrespect and an "us and them" attitude have been implicated in experiences of workplace bullying, effects of which can lead to sick leave and attrition.[27] The potential for these issues to compound midwifery shortages in small maternity units warrants further investigation.

Strengths of this scoping study are that it is unique in looking at the experiences and contributions of SRMs in small maternity units and contributes to existing literature about the midwifery workforce in rural and regional centres. This study also highlights important areas for further research. However, this study is limited in that the views of dual registered midwives about who retains responsibility for overall care of the general patient were not sought, nor their views on supervising SRMs in caring for general patients.

CONCLUSION

This scoping study provides useful recommendations for future research into the experiences of SRMs working in small maternity units in Australia. Findings indicate the perspectives of SRMs and Managers are similar in that SRMs provide a valuable contribution to small maternity units through their midwifery practice and in their role of assisting with general patients when redeployed. However, there is a difference of perspectives about who retains responsibility for overall care of general patients cared for by SRMs. Eliciting the views of dual registrants who work with SRMs may clarify confusion around who is responsible for delegated care and may have provided further insights for future research. Significant workplace challenges faced by SRMs because of their midwife-only qualification have been recommended by participants for exploration in future research, along with scope of practice for assisting with general patients.

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