Community Postnatal Care Provision

In Scotland:

The Development And Evaluation Of A Template

For The Provision Of Woman Centred

Community Postnatal Care

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This thesis is submitted in fulfilment of the requirements for the Doctor of Philosophy in the Faculty of Medicine, University of Glasgow.

DECLARATION

I declare that this thesis was written and all data collected and analysed by myself.

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Date: 6th November 2001

ABSTRACT

Community Postnatal Care Provision in Scotland – The Development and Evaluation of a Template for the Provision of Woman Centred Community Postnatal Care.

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BACKGROUND

The provision of routine midwifery community care to all postnatal women is unique to the United Kingdom. To date little work has been done to evaluate the service, thus creating a fundamental gap in the evidence base midwives have to support and justify the care they provide to postnatal women and their babies, and a dilemma for policy makers and service providers. Recent developments in the provision of hospital postnatal care have focused on moving care into the community and consequently reducing the average number of inpatient postnatal days thus increasing the demand for community postnatal support (SOHHD, 1993; Audit Commission, 1997; Penney et al, 1999; ISD, 1999). In an attempt to fill some of the void, this study investigated women's and midwives perceptions and experiences of community postnatal care. The aim of the study was to establish women's expectations and views of community postnatal care and examine postnatal care provision before and after the introduction of a new model of postnatal care within a university teaching hospital in the West of Scotland.

OBJECTIVES

The specific objectives of the study were to:

1 Investigate women's perceptions and experiences of postnatal care;

2 Examine the current pattern of postnatal care provision in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction:

3 Evaluate the new model in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction;

4 Compare the outcomes of both models;

5 Evaluate midwives' perceptions of both models of care.

STUDY DESIGN

Two consecutive samples of 208 and 205 low risk women were recruited over two five-month periods before and after the introduction of a new model of community postnatal care. The new model provided a template of postnatal visits by the midwife and allowed for negotiation of others, ensuring that wherever possible the woman was seen by the same midwife. In order to determine the midwives perceptions of the postnatal care they offer women, questionnaires were distributed to all midwives working in the community (n=20) in June 1997 and May 1998.

In order to establish women's perceptions and experiences of community postnatal care, primigravid women at thirty-four weeks gestation and again six weeks postnatally participated in focus group interviews between March and August 1997.

MAIN FINDINGS

There were no difference between the two Phases in terms of clinical outcomes (maternal and neonatal) midwifery and maternal satisfaction. In both stages of the study, the average day of postnatal discharge was day three, the mean number of postnatal visits was 4.2, and the average number of midwives to visit a woman was two. Women were very satisfied with the community postnatal care provided by midwives, although concerns were expressed about hospital postnatal care. All women agreed that community postnatal care was an important service and would choose to have the midwife visit her in their own home rather than attend health or drop in centres. Midwives applied aspects of the new template of postnatal visiting and were more likely to visit low risk women three times following introduction of the new template. There was no change in continuity of carer. Findings of focus group discussions highlighted that women were not prepared for motherhood and the postnatal period. Women stated that the educational support antenatally and in the postnatal ward did not meet their expectations and needs.

DISCUSSION

The results highlight that women value the postnatal support offered by midwives following discharge from hospital. A variety of reasons, such as the management of change, traditional working practices, attitudes towards the implementation of a new

model of care, the perceived gap between midwives' and women's expectations of postnatal care and dissatisfaction with hospital postnatal care may have influenced the outcome of this study. The focus group study highlighted that primigravid women were not prepared for the postnatal period and in particular the transition to motherhood. Before introducing any new pattern of community postnatal care /support, attention should be paid to the existing problems such as poorly evaluated preparation for parenthood courses and hospital postnatal care. If these issues are not addressed any attempt to improve/enhance care in other ways will be cosmetic only.

RECOMMENDATIONS

- Identification of research priorities in postnatal care.
- The lack of evidence surrounding use, content and outcome of the routine postnatal check, suggests a need to investigate this examination in more detail.
- Identification of the gaps in knowledge between midwives and women is essential for the development of sound midwifery practice.
- Investigation into the optimum provision of preparation for parenthood education for all prospective and new parents is required.
- An investigation and evaluation of the role, function and duration of hospital postnatal care.

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GLOSSARY OF TERMS

RMS

Abdominal palpation of the uterus.	Used to assess the position, size and consistency of the uterus postnatally.
Antenatal	Before the birth of the baby, during pregnancy
CMB	Central Midwives Board
DOH	Department of Health (England)
DOMINO	Domiciliary In and Out- a system where midwives visiting women in labour at home, bring them into hospital for delivery and discharge them home following a short (less than 24 hours) postnatal stay.
General Practitioner	General Practitioner
Lochia	The vaginal discharges which occur following delivery of the baby. The discharge consists of blood, shreds of uterine lining and other debris. Usually divided into three Phases.
LSA	Local Supervising Authority
MDU	Midwifery Development Unit
Neonatal	Newborn baby up to 28 days old
Perineum	Area of pelvic floor between the vagina and anus
Postnatal	Period of time up to the birth usually up to six weeks Midwives' responsibilities continue for at least 10 days and up to 28 days after the birth.
Postnatal day	This is determined by the time of day the birth took place. Vaginal birth before midday described as day 1, before midday = day 0
Postpartum	After labour
Puerperium	The period after childbirth when the uterus and reproductive organs return to their pre-gravid state (usually 6-8 weeks)
Puerperal sepsis	Infection of the genital tract following childbirth
SOHHD	Scottish Office Home and Health Department
SODOH	Scottish Office Department of Health
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors

THE THESIS

INTRODUCTION

Traditionally the organisation and delivery of postnatal care has been the domain of the midwife. Indeed the UKCC (1998) stresses that during the postnatal period "the continued attendance of a midwife on the mother and baby is a requisite". Yet postnatal care is the area of maternity care which is most heavily criticised (Audit Commission, 1997, Murphy Black, 1989). Recognition of the high rates of postnatal morbidity is a cause for concern (Glazener, Abdalla, Stroud, Naji, Templeton, Russell, 1995). In spite of this information there has been little change in policy and practice to improve postnatal care.

Postnatal care centres around routine postnatal investigations and observations of the mother and baby (Marchant, 1997). The 1990s saw a questioning and criticism of postnatal care and the routine value of the postnatal examination was called into question (Marchant & Garcia, 1995) as postnatal morbidity was not being identified by routine postnatal care (Bick & MacArthur, 1995). Investigations into the effectiveness of some of these routine investigations such as measurement of maternal temperature highlighted that this measurement on its own is not an effective tool for estimation of maternal well-being (Takahashi, 1998). Recent developments in the provision of hospital postnatal care focus on the reduction in the average number of inpatient postnatal days to the current average of three days in 1998 (ISD, 1999), thus increasing the demand for postnatal support once the woman is discharged home. The provision of routine community care to all postnatal women is unique to the United Kingdom, yet little work has been done to evaluate the service, creating a fundamental gap in the evidence base midwives have to support the community postnatal care they provide and a dilemma for policy makers and midwives. For this reason it was considered important to evaluate the content and delivery of community postnatal care and, based on the available evidence suggest ways in which the existing policy and practices could be developed and enhanced within existing resources.

This study was possible because of a Chief Scientist Office Research Training Fellowship. The aim of the Fellowship is to provide research training and experience

for health care professionals. The fellowship was divided into two stages, in the first stage the CSO provided full funding for six months. The purpose of this six month period was to prepare under supervision a sound research proposal which would then be submitted, together with ethical and managerial approval to the CSO for approval. The research proposal was approved subject to minor modifications, 50% of salary and research costs were funded by the CSO for a further 18 months. The remaining 50% was funded by The School of Nursing and Midwifery Studies, The University of Glasgow. The study commenced in April 1997 and a final report was submitted to the CSO in December 1998. This funding and support was extremely helpful but did constrain the timing, nature and approach of the research.

The complete study is comprised of three individual yet complementary pieces of research. In order to yield the information required a combination of research methods and tools were used. A series of focus groups took place to establish primigravid women's attitudes to, and experiences of, community postnatal care. Postal questionnaires, were distributed to postnatal women and community midwives who participated in the before and after study which introduced a woman centred template of community postnatal care.

The specific objectives of the study were to:

1 Investigate women's perceptions and experiences of postnatal care;
2 Examine the current pattern of postnatal care provision in terms of clinical outcomes (maternal and neonatal), maternal satisfaction;
3 Evaluate the new model in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction;
4 Compare the outcomes of both models;
5 Evaluate midwives' perceptions of both models of care.

ORGANISATION AND LAYOUT

There are two sections to the thesis. Section one reflects on the background and methodology of the study. Section two presents and discusses the findings. The thesis concludes by identifying the limitations of the study and makes recommendations for future work.

SECTION ONE

This section provides background information about postnatal care in the United Kingdom. Chapter One sets the scene for the study by explaining the purpose and content of postnatal care. Chapter Two describes the part that midwives and the midwifery profession play in the delivery of maternity services, in particular postnatal care. Chapter Three highlights issues related to the delivery and outcomes of postnatal care provision and Chapter Four, the final chapter in this section, describes the aims and methodology of the study.

SECTION TWO

This section presents and discusses the findings of each study. Chapter Five presents and discusses the findings of the focus group study of primigravid women at 36 weeks gestation and again six weeks postnatally which established women's perceptions and experiences of community postnatal care. Chapter Six presents the findings of the before and after study which introduced a new template of community postnatal care. Chapter Seven discusses the findings presented in Chapter Six and addresses midwives and women's perceptions of, and satisfaction with both methods of community postnatal care provision. The final chapter (Chapter Eight) integrates and summarises the key points from the studies. It presents the conclusions, suggests implications for practice and makes recommendations about future work.

SECTION ONE

CHAPTER ONE

POSTNATAL CARE IN SCOTLAND – AN OVERVIEW

This chapter provides background information about postnatal care in the United Kingdom. It sets the scene for the study, by describing the purpose and content of postnatal care. This theme will be developed by examining the present pattern of postnatal care provision. The historical events and statutory framework, which have shaped the way postnatal care is delivered in the UK today, will be described. The chapter concludes by highlighting the impact which policy and organisational changes have had on the provision of postnatal care, in hospital and in the community.

1.1 Definitions Of The Puerperium And The Postnatal Period

The puerperium is defined, as the period from birth until six weeks after the baby is born (Bennett & Brown, 1993). During this time the reproductive organs return to their pregravid state, lactation is established and the woman recovers from pregnancy and childbirth. This period culminates in a six-week physical postnatal check, usually carried out by a General Practitioner or obstetrician to ensure that all has returned to normal (Bennett & Brown, 1993). The postnatal period differs from the puerperium and is defined as

> *"a period not less than ten days and not more than twenty eight days after the end of labour, during which the continued attendance of a midwife on the mother and baby is a requisite."*
> *(UKCC, Midwives' Rules 1998)*

These definitions have evolved over the years. In 1919 the lying-in period was described as "in a normal case to mean the time occupied from the labour and a period of ten days thereafter" (CMB, 1919). By 1952 the lying in period was defined as

> *"a period not less than fourteen days nor more than twenty-eight days after the end of the labour during which the continued attendance of the midwife on the mother and child is requisite."*
> *(CMB, 1952)*

This definition clearly identifies the responsibility of the midwife during this time and apart from the reduction from fourteen to ten days remains the same today (Garcia & Marchant 1996).

1.1.1 The purpose of postnatal care

Postnatal care was intended to improve maternal health after childbirth. Traditionally postnatal care centred on physical recuperation. The care that midwives gave postnatal women has always been seen as essential to good midwifery practice and the well being of mother and baby. Maternal death following childbirth is now relatively rare, although the most recent review of maternal deaths identified twelve maternal deaths due to haemorrhage and a further ten due to sepsis associated with genital tract infection in the two year period from 1994-1996 (DOH, 1998). Therefore, 16.4% of all deaths (22 of 134) directly associated with pregnancy are still related to the puerperium. The focus of postnatal care tended to be on maternal morbidity and indeed, this continues to be the case (MacArthur, Lewis, Knox, 1991; Glazener et al, 1995; Cheyne, Hillan, Morris, Reid, Tierney, Lyall, 1999). The main causes of maternal death in the UK are thrombosis, hypertensive disorders of pregnancy and haemorrhage (DOH, 1998).

The physical, emotional and educational needs of the new mother are now well documented (Rider, 1985; Ball, 1987; Murphy-Black, 1989; Garcia & Marchant, 1993). However, postnatal care is still poorly evaluated (Audit Commission, 1997) and women continue to experience problems, which are largely undetected by the professionals (Garcia & Marchant, 1993). Studies highlight that many women experience some form of problem in the first six weeks after delivery (MacArthur et al, 1991; Glazener, Abdalla, Stroud, Naji, Templeton, Russell, 1993) and evidence suggests that appropriate help at the right time can prevent or reduce postnatal depression (Holden, Sagovsky, Cox, 1989).

The transition to motherhood involves physical, emotional and psychological changes. Women experience concerns about their own recovery and knowledge deficits, especially in relation to the care of the newborn (Fishbein

& Burggraf, 1998). Postnatal care can reduce the risk or minimise the outcome of physical and psychological complications such as infection, thrombosis, anxiety and depression (Glazener et al, 1993; Cox, Holden, Sagovsky, 1987).

Postnatal care gives women the opportunity to receive appropriate educational support and facilitates discussion with the midwife. Although it is acknowledged that the needs of postnatal women have changed since the turn of the century, concern exists that the care and support offered to women by midwives does not always reflect this (Garcia & Marchant 1996). Introducing patterns of postnatal care provision which change the emphasis of care and which reflect maternal history, physical, psychological, psychosocial and educational need should increase maternal satisfaction and reduce morbidity and distress amongst postnatal women.

1.1.2 The present pattern of postnatal care in Scotland

All women are supported by a variety of health care professionals following the birth of a baby. These professionals, who include midwives, General Practitioners, physiotherapists and heath visitors, offer care, advice and education for all new mothers. Patterns of midwifery care including postnatal care have changed markedly (Murphy Black 1992) and will be discussed in greater detail later on in this chapter. During the postnatal period the midwife is the key health care professional in regular contact with women. She determines the need for postnatal visits, physical and emotional support and other professional involvement. As the main professional carers for postnatal women midwives play a key role in providing physical, social, educational and emotional support to women in the postnatal period (Rider, 1985; Hodnett, 1993; Holden et al, 1989).

In Scotland the majority of women are delivered in hospital. Whilst in hospital midwives support, educate and care for new mothers and their babies. The midwife is ideally placed to provide all the care and information needs for the woman and her family. However, criticism exists that many mothers do not get the care and attention they need whilst in hospital (Murphy Black,

1989; Ball, 1994). The average postnatal stay in hospital is currently three days (ISD, 1999). The baby is examined twice by a paediatrician, initially after birth, and then prior to discharge. Following discharge from hospital the community/team midwife will continue to visit the woman and her baby up to twenty eight days after the birth, although the majority of women are discharged from the community midwife at day eleven (QMH, 1996).

The midwife and health visitor play a key role in increasing parents knowledge and confidence in their parenting skills (Garcia & Marchant, 1999). Following discharge from the community midwife, the health visitor will contact the woman and arrange an initial assessment visit. The health visitor monitors the well-being of mother and baby, assesses child development and offers educational advice and support to the new mother. Child immunisation and vaccination programmes are operated at Trust level and mothers are prompted by written reminders to take the baby for his/her vaccinations. Traditionally the health visitor monitors child development until school age, but in recent years she/he has played a key part in providing support and education for parents. As the health visitor maintains contact with the family she/he is one of the health care professionals ideally placed to monitor maternal well-being and detect postnatal depression.

The General Practitioner also continues to care for the woman in the postnatal period. The midwife will contact him/her if the woman or baby is experiencing any problems. As part of their contract with the NHSiS, General Practitioners are meant to pay at least one visit to the new mother and her baby, although it appears that only 75% of General Practitioners actually carry out this visit (Audit Commission, 1997). The General Practitioner is the health care professional most likely to carry out the six-week postnatal check and this marks the end of the postnatal period for the woman, however there is controversy about the content of this check (Gunn, Lumley, Young, 1998)

1.1.3 Current policies on postnatal care and home visiting

Most women in Scotland deliver in hospital and remain there for an average of three days. Culturally, Scotland is different from the rest of the UK; women

do not request home confinements in the same quantities as elsewhere. In a recent audit of maternity services in Scotland, the majority of women (87.2%) thought that the length of stay in hospital after delivery was just right (Penney, Graham, Hundley, Teglingen, Rennie, Fitzmaurice, Heddle, 1999). It is still routine for midwives to visit postnatal women in their own home up to at least ten days after the birth. In the majority of instances the midwives undertaking such visits are community midwives, although some Trusts have introduced team midwifery and all members of the team participate in the community postnatal care. At these postnatal visits the midwife may examine the baby and complete a physical examination of the mother to establish physical recovery from the birth. Although the routine postnatal check which will be discussed later on in this chapter has been called into question there is no doubt that postnatal examinations still have an important place in routine postnatal care (Bick & MacArthur, 1994). Midwives make a record of the findings from the postnatal visit and arrange a mutually agreeable time to visit again.

Recently midwives have been encouraged to provide a holistic approach to postnatal care. Garcia and Marchant (1996) argue strongly for a re-evaluation of the purpose of postnatal home visiting. They stress that the focus of care should be on the reduction of morbidity, which affects the ability of the mother to return to reasonable health rather than screening everyone for serious outcomes, which affects only a few. Recommendations were made in the late 1980's to alter the pattern of postnatal visits. However, Garcia & Marchant (1996) note that there has been very little discussion about the meaning of selective visiting or the criteria midwives use to determine who should be visited.

Maternal morbidity is still an issue and in some studies up to fifty percent of postnatal women reported at least one health problem which lasted more than six weeks (MacArthur et al, 1991; Glazener et al, 1993). The routine work of midwives on the postnatal ward is still based on the detection of abnormalities and has varied little in recent years (Garcia & Marchant, 1996). Skills are required to prioritise the essential components of midwifery care for each visit.

Concerns exist that early postnatal discharge and the high proportion of women who do not attend preparation for parenthood courses may mean that many women are inadequately prepared for discharge from hospital. In many instances the midwife must devote time to providing educational support on a one – to - one basis. Although this is beneficial for the woman it is a costly exercise in economic terms. Much of this education could be done as effectively in small group tutorials postnatally.

Traditionally much midwifery care has been based on routine and is task orientated (Garcia & Marchant, 1996). The introduction of selective postnatal visiting should go some way towards individualising care and increasing the chance of continuity of carer. Postnatal care should be tailored to meet individual needs, but midwives must be able to identify women who require added postnatal support and use this information to plan and inform their practice.

The home visiting policy, which exists in the UK is unique, yet the changing social and cultural environment of women suggests an even greater need for midwifery support in the postnatal period. The adoption of selective postnatal visiting would allow midwives to concentrate their efforts on where they are needed most. This should in turn increase continuity of carer and reduce the risk of duplication of resources and conflicting advice. What has not always been included or taken into account in the development of postnatal care practices are the changing demands and expectations of women. Women's expectations and information needs will depend on parity, prior experience, social support, psychological well-being, self-confidence, educational attainment, and prior support and education from midwives and other health care professionals antenatally and postnatally (Nolan, 1997).

1.1.4 Concerns and criticisms with current postnatal care provision

In recent years the changes in the delivery of maternity care have resulted in some unforeseen effects on care provision. It was the way maternity care in the NHS was organised which created a tripartite system which resulted in a fragmentation of service provision. The tripartite administration meant that a

pregnant woman might receive maternity care from professionals working in three separate authorities, her general practitioner, hospital staff and the community midwife. Hospital became the venue for the majority of deliveries. Thus, community midwives lost the continuity of care they had previously enjoyed. Since the 1980s, the community midwife's role centred on community postnatal care with an increasing involvement in antenatal care provision. Although most midwives were orientated to each aspect of midwifery care on qualification, the majority was then allocated to specific wards resulting in a subsequent de-skilling of many midwives. In recent years attempts have been made to ensure that the skill base of all midwives is maintained. In spite of the systems in place to support new mothers, postnatal care is the most heavily criticised aspect of maternity care especially with regard to:

- Hospital postnatal care (Audit Commission, 1997);
- The failure to detect and treat complications as the arise and the continued concerns about maternal health after childbirth (MacArthur et al. 1991; Glazener et al. 1993);
- The lack of evidence to support the postnatal care given to women (Ball, 1994);
- Failure to adequately prepare women and their partners for parenthood (Nolan, 1997).

1.2 History Of Postnatal Care

Midwives in Scotland were doing postnatal visits in accordance with the CMB Rules since 1916. Formal community based postnatal care was not implemented until after the setting up of the NHS in Scotland although the importance of postnatal care in the prevention of maternal morbidity and mortality has been recognised for many years. Specific mention was made of the importance of postnatal care during the House of Commons debate surrounding the Maternity Services (Scotland) Bill (1937). A Scottish MP, Mr T. Johnston said

> *"In Edinburgh they followed up maternity cases after the women had left the clinic supposedly cured. They discovered that in 30% of those cases there were women who had serious illness and remained seriously ill for long periods after they had been*

discharged from the clinics. So that we are facing not only a mortality rate of 6:1,000, but also a very high sickness rate arising from our maternity arrangements." (Hansard, 1937)

1.2.1 Statutory regulation – Midwives' Acts

The history of postnatal care and in particular the role of the midwife played can be traced through the statutory instruments and early midwifery textbooks. In the early part of this century most births took place at home and women paid for this service.

The Midwives Act (Scotland) of 1915 recognised the midwifery profession in statute. Before the turn of the century little control was exerted over women who acted as midwives and high maternal and neonatal morbidity rates were a cause of concern. Up until the passing of the 1915 Midwives (Scotland) Act any woman in Scotland could call herself a midwife and could practise as a midwife. From the first of January 1916 when the Act came into operation no woman, unless certified under the Act, could call herself a midwife or imply that she was certified. From 1 January 1922 no uncertified midwife could practise 'habitually and for gain' unless under the direction of a registered medical practitioner. Following the 1915 Midwives (Scotland) Act, the Central Midwives Board for Scotland (CMB) was established. The CMB was set up as an examining and supervisory body. It remained in place until it was taken over by the National Board for Nursing, Midwifery and Health Visiting for Scotland in July 1983 (Reid, 1999).

The statutory instruments such as the Midwives' Rules set out clearly what the midwife's role and responsibility was during the puerperium. The Central Midwives Board produced handbooks, which can now be used to identify the changing role and function of midwives in the postnatal period since the beginning of the century. A Scottish Examining Board for Obstetric Nurses was set up in 1902, before the 1915 Scotland (Midwives) Act (Dow 1984). Consequently midwifery training programmes were developed and approved. But the transition, from using a 'handywoman' or 'howdie' as she was called in Scotland, to a trained midwife was a slow process and took some years to take effect. Many women were unable to afford the services of a doctor to

care for them whilst in labour and instead paid the 'howdie' and subsequently the midwife to care for them in labour and in the postnatal period. Apart from the obvious difference in skills and education the handywomen helped with the cleaning and cooking for a limited time postnatally (Murphy-Black, 1989).

As early as 1919 (CMB, 1919), midwives duties to the postnatal mother were made explicit. Implicit in the Midwives' Rules was the notion of daily head to toe examination of the woman. Clear guidelines were laid down to ensure that women were cared for adequately during this time. The guidelines included prescriptions about the timing and content of postnatal visits. The main priority of the midwife was to examine the woman and baby and be constantly on the lookout for deviations from the normal especially indications of infection or circulatory problems. The midwife was deemed responsible for: 'the cleanliness, and shall give all necessary directions for securing comfort and proper dieting of the mother and child during the lying-in period'. A list of abnormalities including convulsions, offensive lochia, abdominal tenderness and white leg were identified as cases where the midwife must summon medical aid (CMB, 1919).

Maternal and neonatal morbidity and mortality was such a concern in the early decades of this century that the Government of that time commissioned reports to investigate the situation (Mackenzie, 1917). The Central Midwives Board for Scotland worked to increase the standard of midwifery practice, but recognised that

> *"a certain latitude must be accorded to midwives in Scotland, who have been enrolled in respect of practice but who have not received any previous training."* *(CMB, 1918)*

Although the Local Supervising Authorities supported and helped educate the 'bona fide' midwives, many midwives were reported to the LSAs for non-compliance with the Rules. A CMB report (1921) highlighted the gulf, which separated the women who presented themselves for examination of the Board and those who enrolled by virtue of their bona fide practice at the passing of the Act. The report recognised that although bona fide midwives were more experienced, many were unable to take temperatures or pulse and could not be

relied upon to recognise 'nature's danger signals'. Review of CMB Minutes between 1916 and 1922 highlights the number of midwives who went before the Board for non-compliance with Rules (Reid, 1999). In the majority of instances these cases were related to Rules related to care of mother and baby in the postnatal period. Work carried out by the LSAs and local staff to support midwives helped increase the standard of midwifery care in the postnatal period.

As the years progressed more women used the services of certified midwives. As the majority of births took place in the home, midwives provided care during labour and immediately after the birth and delivered the statutory ten days requirement for postnatal care. Concern existed that many women continued to use 'howdies' as they were cheaper than midwives. Doctors were rarely involved in normal births, largely because of the fees they charged. Maternal morbidity during this era was high. In Scotland in 1922 the maternal mortality rate was six per 1,000 births (Hansard, 1937), and it remained the same in 1935. The main causes of maternal mortality identified in the reports were sepsis and haemorrhage.

The 1937 Maternity Services (Scotland) Act meant that all pregnant women had the right to the services of a qualified midwife for up to 14 days after the birth free of charge. The 1937 Act was intended to weed out the last of the howdies and reduce maternal mortality. Many maternity hospital directors had reservations about the Bill and believed the outdoor system of maternity care was essential for training students and nurses (Dow, 1984).

Following on from the 1937 Act came the setting up of the National Health Service in 1948 following the NHS Act (Scotland) in 1947. These two major changes within a decade were to change the face of maternity care in Scotland and the UK for the rest of the century. Until 1938, routine maternity care, especially antenatal and intrapartum, was the domain of the midwife. Only a very small number of women were admitted to hospital for maternity care and the accepted practice was that all care would be delivered in the woman's home. Following the National Health Service Act in 1947, mothers could, for

the first time, have a doctor in attendance without paying a direct fee (Wood, 1963). State payment for health care influenced professional attitudes to maternity care and there was a move by doctors to claim responsibility for maternity care. Gradually the focus of maternity care became the hospital and all women were assigned an obstetrician to care for them during their maternity care episode.

The first set of statutory rules published by the CMB for Scotland stated that the midwife must attend during 'the time occupied by labour and a period of ten days thereafter' (CMB, 1916). This continued and was included in subsequent rules until the Rules of 1939 when the minimum for postnatal visits was increased to not less than fourteen days, (NBS Rules framed by the CMB for Scotland, 1939). This was reduced to ten days again in the Rules of 1965. This rule continues in the Scottish Rule Books until at least 1968 with no mention of the 28 days of which the English Rule Book/Handbook speaks. The tripartite structure (hospital, local authority and general practitioner) of the NHS increased the likelihood of duplication in Maternity Medical Services. In the early 1960s most District services (Domiciliary Midwifery Services) were closed on the instructions of the DHS (Dow, 1984).

The role of the midwife continued to develop during the first half of the century. Midwives were expected to visit and examine each postnatal woman daily but if any abnormalities were found at a visit then an extra visit was to take place later that day. The list of problems was clearly identified and became more explicit for midwives as were the various courses of action should a complication arise (CMB, 1952). As the years progressed the introduction of antibiotics combined with more vigilant support of postnatal women resulted in an improvement in the rates of maternal morbidity following childbirth. In 1998 the Midwives' Rules and Code of Conduct were combined and published in the same booklet thus stressing the importance of both documents in midwifery practice (UKCC, 1998).

Although statute has changed very little over the past seventy years, the Midwife's Code of Practice has changed considerably in focus and content

(Garcia & Marchant, 1996). Midwifery practice in the postnatal period is regulated through statute by the Midwives' Rules (UKCC, 1998). A midwife also follows the non-statutory guidelines in the Midwife's Code of Practice (UKCC, 1998).

The structure and emphasis of the Midwives' Rules changed over the years. Initially the Rules were prescriptive and identified specific tasks and responsibilities for the midwife. More recently, the UKCC has used broader statements that reflect the nature and philosophy of postnatal care. Since 1986 the UKCC code of practice was less prescriptive and did not give the same instruction about timing, number and content of postnatal visits. The directive about daily visiting was removed and guidance about referral to a doctor became more general (Garcia & Marchant, 1996). These changes caused some confusion within the profession. In 1992 the UKCC sent a letter to all midwives that clearly defined and explained the role and function of the midwife in the postnatal period,

> *"each midwife is personally responsible and accountable for the exercise of professional judgement and determining the appropriate practice in relation to mother and baby. This, naturally, includes judgements about the number of visits and any additional visits required in the postnatal period."*
>
> *(UKCC, 1992)*

However, far from clarifying matters, the letter appeared to increase the confusion about postnatal care. Whilst the intention was to give midwives more autonomy and an opportunity to develop and use their decision-making and critical thinking skills by providing individualised postnatal care, the reality was that very little professional debate about this occurred.

1.2.2 Domiciliary midwifery and the development of postnatal care

During the early thirties the term 'domiciliary midwife' began to be used (Munro Kerr, Haig Ferguson, Young, Hendry, 1923). The bulk of the care the domiciliary midwife delivered was during labour and the immediate postnatal period. Midwives worked long hours caring for labouring women and irrespective of the number of hours worked were still required to visit postnatal women. In the first third of this century over three quarters of births were at home and largely under the care of the midwife. Midwives' income

was derived from the fees they charged women. In poorer areas midwives had to book many confinements to be able to earn a living (Murphy-Black, 1989). During this era maternal mortality was very high (6 per 1000 births in 1935) and the focus of postnatal care was on the detection of abnormality. Puerperal sepsis was recognised as a potential killer and midwives were required to send for medical aid in specific cases such as offensive lochia, raised temperature or other indications of infection.

With the increased number of hospital deliveries from the 1950s onwards there was a corresponding change in the role of the domiciliary midwife, who no longer cared for the woman throughout the whole of her pregnancy, labour and puerperium (Murphy Black, 1989). The domiciliary midwife became known as the community midwife.

Traditionally community midwives were based in the community either attached to General Practitioner practices or in a specific geographical area. Integration of hospital and community midwifery services meant that community midwives were based in hospital and under the control of midwifery managers and sometimes obstetricians. The average postnatal stay in hospital gradually reduced from day ten in the 1950s (Theobald, 1959), to 5.3 days in 1980, 4.4 days in 1986 (ISD, 1981, 1988) and three days in 1998 (ISD, 1999). The changes in maternity care delivery resulted in a shift of focus for community midwives resulting in the provision of what might be perceived as less care to more women (Murphy Black, 1989). What community midwives felt about the change in their role and responsibilities are matters for speculation given that there was no research to evaluate the change.

1.2.3 The development of hospital postnatal care

Following the NHS Act (1947) more and more women had their babies in hospital. Midwives were designated to work in hospital or in the community. The average duration of inpatient postnatal stay in the post war years was 10 - 14 days and much of this time was spent in bed (the lying in period). Obstetricians and, to a degree, General Practitioners controlled postnatal care,

depending on whether the delivery was at a general or rural General Practitioner run hospital. Care was provided by midwives, student midwives and nursery nurses. Hospitalisation following childbirth was traditionally a time to ensure that mother and baby were well and had adjusted to the birth; it was a time for planning care, setting priorities, educating and supporting women. The evacuation of women and children from large cities during the Second World War meant that many women had their children in hospital or nursing homes and remained there for the 'lying in' period. This trend continued after the war. Gradually there was a shift in the place of delivery from home to hospital and the demand for hospital deliveries increased (Oakley, Rajan & Grant, 1990). By 1958 the majority of women delivered in hospital and remained there for ten days after delivery (Murphy-Black, 1989). Longer hospital postnatal stays were thought to facilitate the transition to motherhood (Fishbein & Burggraf, 1998).

The increase in maternity bed occupancy and the rising birth rate began to stretch the service and by the late fifties moves were afoot to decrease the length of hospital postnatal stay (Theobald, 1959). Changes in the delivery of maternity services, increased antenatal care, early ambulation postnatally, the increase in awareness of aseptic techniques combined with the use of sulphonamides and other antibiotics resulted in a reduction in maternal mortality, thus reducing the need for prolonged hospital postnatal stay (Wood, 1963).

In a review of Domiciliary Midwifery and Maternity Bed Needs, the Peel Report (1970) recommended that obstetric resources and emergency facilities should support maternity care. It advocated 100% hospital delivery for mothers in England and Wales and over the next 10-15 years extra maternity beds were provided. Although the Peel report was not applicable in Scotland the maternity services in Scotland followed the trend. This report resulted in the dismantling of domiciliary care and an increase in hospital care.

It has been argued that the early postpartum period is not the ideal time for extensive teaching as the mother has different priorities at this time (Lemmer,

1986). If women are discharged early then this may mean they have less opportunity to practise newly acquired mothering skills under supervision. Hospital postnatal care, although a new concept for midwives, was initially under the medical domain and its traditional organisation reflected a medical model and did not appear to be successful in its attempts to support women. The stay in hospital remains an important opportunity to address the social needs of mothers and their new babies (Ball, 1994). It is reasonable to hypothesise that women with increased risk factors will spend more time in hospital than those of low risk (Margolis & Kotelchuck, 1996). Although hospitalisation was seen as an opportunity to help recovery, detect complications and generally facilitate the transition to motherhood, evidence suggests that many women did not feel prepared for motherhood on discharge from hospital (Rogan, Shmied, Barclay, Everitt & Wyllie, 1997).

Criticism of hospital postnatal care led professionals to question the way in which postnatal care was provided in hospital. There appears to be little foundation in the current practice that all women require a minimum stay in hospital postnatally. Questions were first asked in the late 1950s (Theobald, 1959) yet although early postnatal or 48 hour discharge has been available to women for over 30 years, only a minority of women took up this option. A long hospital postnatal stay became the accepted norm. However, recent Government reports and reviews and changing expectations, together with international evidence, has resulted in a review of this practice.

1.3 Organisation Of Postnatal Care

The 1990s saw a renaissance of maternity care in the community. However, though the organisation and delivery of maternity care has altered, there is little evidence to support the care being offered (Bick, MacArthur, Winter, Fortune, Henderson, Liliford, Gillies, Gee & Belfield, 1997). The changing nature and focus of maternity care has resulted in an increased and different workload for community midwives without a reallocation of finances and resources. Although hospital postnatal care is poorly evaluated, the opposite is true for community postnatal care. The Scottish Policy Review (1993) highlighted the high levels of dissatisfaction associated with hospital postnatal

care and also stressed the high cost of inpatient postnatal stay. McCourt & Page (1996) highlighted that most women were very satisfied with home care irrespective of their model of care. Other countries aspire towards providing similar patterns of care, which they believe will result in benefits for the woman (Gupton & McKay, 1995; Williams & Cooper, 1993).

1.3.1 Timing of the postnatal visit

Traditionally the role and function of midwives in community postnatal care was clearly identified but the Midwives' Code of Practice (1998) no longer includes a directive specifying the number of postnatal visits a woman should receive. Selective postnatal visiting was intended to improve continuity of care and carer (Poole, 1999), thus increasing maternal satisfaction (Twaddle et al, 1993) and avoiding conflicting advice (Murphy Black, 1989). In 1994 the Royal College of Midwives Standing Practice Group published a paper on 'Community Postnatal Visiting'. The paper clearly identified the role, purpose and potential of community postnatal visits and highlighted key points that midwives should consider when organising and delivering community postnatal care. It stressed that:

- The woman should be at the centre of care;
- Each visit should have a purpose for mother and baby rather than just being routine;
- A partnership approach to care should be developed with the woman;
- Postnatal care should encourage independence rather than dependence;
- Decisions about visiting should be made for sound clinical reasons in consultation with midwives;
- The role of postnatal care should not be eroded but evaluated and enhanced.

These points clearly support the notion of the midwife, in consultation with the woman, working autonomously and using her clinical judgement to support the decisions made about care.

In a survey of health districts in England, Garcia, Renfrew & Marchant (1994) found that postnatal visiting policies existed in eighty-one of the 176 areas surveyed but that the policies varied from district to district. Implicit in the

selective visit directive (UKCC, 1992) was the acknowledgement of the need for professional judgement by the midwife and informed choice by the woman. Garcia et al, (1994) questioned how midwives make decisions about when to make a home visit. Information about how midwives decide the number of postnatal visits has important organisational and economic implications. Community midwives are expected to be able to discriminate between women who need a postnatal visit and those who do not. Indeed, Garcia et al (1994) called for an audit of postnatal home visiting in terms of women's social and obstetric characteristics. Recent work has examined midwives and women's views about patterns of postnatal care (Hamilton, 1998) and looked at the effect of selective visiting on maternal anxiety (Poole, 1999).

Although both of these studies are small, the findings raise issues, which are worthy of further investigation. Hamilton (1998) found that midwives believed that selective visiting improved the service to women and gave them control in making choices regarding their care. Women however, were not as positive in equating selective visiting with improved care and said that they did not always have the information or opportunity to choose the number and timing of visits. The study suggested that although midwives thought they were offering women choices, many of the decisions regarding visits were made by the midwife and were influenced by issues such as workload and whether it was a weekday or the weekend. Hamilton (1998) argued that as postnatal care was traditionally poorly perceived, midwives might still undervalue the importance of postnatal care. Some midwives expressed concerns that new mothers might be anxious if postnatal visits were selective, yet Poole (1999) found that selective postnatal visiting did not affect maternal anxiety levels. Hamilton (1998) questioned how midwives make decisions about a home visit especially as a different set of decision making criteria seem to be used at the weekend.

1.3.2 Background to the routine postnatal examination by the midwife

Midwifery textbooks explained explicitly how and when to complete the postnatal examination considered necessary to detect deviations from the

normal. The nature, frequency and content of postnatal visits were clearly identified. Midwives were told to examine a woman twice daily until seventy-two hours following delivery and thereafter daily until at least day ten, but up until day twenty-eight, if necessary (Myles, 1975). Where women had DOMINO deliveries or were discharged from hospital early the community midwives visited the woman twice daily up to seventy-two hours and daily thereafter. Most midwifery textbooks were prescriptive and instructed midwives on the content of the postnatal examination. All women irrespective of history or risk assessment were required to have a complete postnatal examination (Myles, 1968).

The content of the examination was explicitly described in well-known midwifery textbooks (Myles, 1975; Sweet, 1988; Sweet & Tiernan, 1997; Bennett & Brown, 1989; Ball, 1994). Included in this examination were:

- Maternal temperature, pulse and blood pressure: - It was noted that the temperature and pulse should be checked and recorded twice a day for the first few days then once until the tenth day. Textbooks highlighted that as any rise in pulse may be indicative of bleeding or possible puerperal sepsis, a pulse rate of over ninety beats per minute should be reported to a doctor irrespective of the maternal temperature;
- Blood pressure recorded on the first day and repeated if necessary;
- Breast examination carried out at every visit;
- Examination of fundus including measurement of fundal height and assessment of uterine involution;
- Perineal examination, to rule out any signs of infection;
- Observation of lochial discharges - including the character, volume and colour; - midwifery textbooks described explicitly the nature of the lochia and its changes following delivery, although the reliability of this information is now called into question (Marchant, 1999);
- Examination of legs to identify tenderness or signs of deep venous thrombosis;
- General assessment of physical well-being, including the prevention of infection and promotion of rest;
- Assessment of emotional well-being.

A review of the leading midwifery textbooks from 1953 to 1989 (Myles, 1953,56, 58, 61, 64, 68, 71, 75, 81, 85; Bennett & Brown, 1989, 93; Sweet, 1988) identified little change in the nature and function of the postnatal examination irrespective of the changes in statutory guidelines during that time.

In detailing the nature of the routine postnatal check, Bennett & Brown (1989), state that a midwife who examines the uterus and lochia is more likely to detect deviation from the normal physiology if she examines the woman on successive occasions.

In practice the nature and content of the postpartum visit varies from midwife to midwife. Many midwives follow a routine observation sheet for mother and baby which ensure that all clinical observations are performed. Work carried out by Murphy Black (1989) and Montgomery & Alexander (1994) found that midwives concentrate on physical investigations when providing postnatal care. The argument is made that the content of postnatal visits reflects the midwife's perception of need rather than that of the mother. This view is substantiated by Marsh and Sargent (1991) who found that the presence of health, social or emotional problems or lack of family support, was not associated with longer postnatal visits.

1.3.3 Content of the postnatal examination

In reviewing the evidence related to the delivery and content of postnatal care, very few studies were found to establish exactly what happened during a postnatal visit, the rationale for identified care and the outcome. Most postnatal studies incorporated some work related to the timing of postnatal discharge, postnatal visiting policies or were international in origin (Twaddle et al, 1993; Astbury, Small, Brown & Lumley, 1994; Small, Lumley & Brown, 1992). Only two Scottish studies (Murphy-Black, 1989; Marsh & Sargent, 1991) explored what happened during midwifery visits. In Murphy-Black's study, questionnaires, which asked about the content of postnatal visits, were distributed to women ten days, four weeks and three months postpartum.

Findings of this study highlighted that the majority of women had physical examinations such as abdominal examination. Murphy-Black (1989) found that certain physical tasks such as examinations and maternal temperature were undertaken on nearly all mothers irrespective of need and in spite of changes to the Midwives' Rules. In an attempt to establish factors, which influence the duration of postnatal visits, Marsh & Sargent (1991) established that midwives concentrated on the tasks related to physical care of the mother and baby and in 91% of visits the woman was examined by the midwife. Questioning the nature and content of the postnatal visit should help establish midwives' perceptions of their role and function in the postnatal period.

In a study which examined the content of the postnatal examination Marchant & Garcia (1995) highlighted that although midwives said that they were selective in the investigations they carried out on postnatal women, the women indicated that many midwives tended to complete the "full" postnatal check routinely. The midwives in this sample were experienced and, although aware of the needs and priorities of women, continued to complete investigations in which the midwives themselves saw little value. Much of the recent evidence surrounding investigations which form part of the 'routine' postnatal examination suggest that midwives should discriminate between the investigations they carry out (Cluett, Alexander & Pickering, 1997; Montgomery & Alexander, 1994; Takahashi, 1998; Poole, 1999). Although the postnatal examination is just one element of the postnatal visit, physical examination of mother or baby is considered the most time consuming element (Marsh & Sargent, 1991). The physical tasks associated with the postnatal examination seem to reflect the midwives perception of what the mother wants rather than the mothers' (Marsh and Sargent, 1991; Marchant & Garcia, 1995).

The planning and organisation of postnatal visits is crucial to the amount of time that can be allocated to each woman. Evidence suggests that there are factors that are associated with longer visits and using this information helps workload management and enhances patient care (Marsh & Sargent, 1991).

1.3.4 Satisfaction with hospital postnatal care

Ball (1987) highlighted that much postnatal practice was based on ritual and routine rather than evidence and evaluation of existing care. The Health Committee's second report (DOH, 1992) suggested that lack of research or poorly evaluated practice contributed to unacceptable standards of postnatal care. Consumers highlight poor support, lack of staff, conflicting advice amongst others as reasons for the existing standard of postnatal care (Gready, Newborn, Dodds & Gauge, 1995; Audit Commission, 1997; Penney et al, 1999). The recommendations to research the broader aspects of postnatal care have yet to be adopted, possibly reflecting the maternity care priorities of that time.

Significant dissatisfaction with hospital postnatal care, irrespective of the scheme of care offered, has been highlighted (Audit Commission, 1997; DOH, 1993; SOHHD, 1993; Field, 1985; Stamp, Williams & Crowther, 1995; Bostock, 1993; McCourt & Page, 1996; Gready et al, 1995). Factors which impact on hospital postnatal care and outcome include: rituals, ward routines, shift changes and fluctuating workload (Ball, 1994). Complaints about postnatal care centred on the environment, conflicting advice, lack of support, education, rest and attention (Gready et al, 1995; Audit Commission, 1997). Postnatal care was considered by many to be 'low tech' and 'low status' (Rider, 1985; Ball, 1994) and this may have influenced its development over the years. The way in which hospital postnatal care was, and possibly still is, viewed may have impacted on the quality of staff recruited to deliver postnatal care. Rider (1985) argued that the medical model adopted by maternity units resulted in a model of postnatal care that failed to meet the non-physical needs of new mothers. Midwives seem to have ignored the wave of opinion and evidence surrounding the timing of postnatal discharge. In doing so they have paved the way for even earlier postnatal discharge without evidence to support its impact on the service, midwives or women. Walsh (1997) stated that midwives must be aware that managers are questioning the role and function of postnatal care.

The evidence available concerning hospital postnatal care tends to be derived from larger studies and is mainly negative (Audit Commission, 1997). What remains unclear is whether decreasing hospital postnatal stay is likely to overcome problems such as lack of rest, lack of continuity of care, conflicting advice and postnatal morbidity. Walsh (1997) argues that in the current economic climate midwives must be proactive and should question the optimum duration of hospital postnatal stay. In many instances factors such as staff shortages, reduced bed occupancy, pressure on maternity beds and economic factors influence the decision to introduce shortened hospital postnatal stays without evaluation of existing patterns of hospital postnatal stay (Waldenstrom, 1989). Evidence suggests that women are happy with their care if they get the care they expect (Porter & McIntyre, 1984; Lothian Maternity Survey, 1992). Problems only seem to arise if women get less care than anticipated e.g. discharging home earlier than anticipated. There is no doubt that planned early discharge decreases pressure for postnatal beds. However, what has never been established is whether this reduces the overall cost of postnatal care (McIlwaine, Cole & Twaddle, 1994).

Effectively the tradition of postnatal care and in particular inpatient care in the UK has been unchallenged for almost thirty years. Until the late 1980s there was little evidence of consumer pressure to reduce inpatient stay. Research in the early 1980s highlighted that parentcraft education in hospital was minimal and this added to the stress of being a new mother (Laryea, 1989). In many instances mothers approached other agencies such as the National Childbirth Trust. These agencies eventually bridged the gap in education and support for some women (McKim, 1995). Women were clearly not happy with the organisation and delivery of postnatal care (McIlwaine et al, 1994; McCourt & Page, 1996; Audit Commission, 1997). Although women were discharged from hospital earlier than before, models of care and education to support a reduction in hospital postnatal care were not established.

The move towards early postnatal discharge was subtle and happened over time without staff recognising the ultimate impact on care and workload. Those who were prepared for early postnatal discharge viewed the experience

positively while women who had early postnatal discharge 'thrust' on them were more likely to be dissatisfied with care (Waldenstrom, 1989). Reasons postulated for satisfaction with postnatal care include involvement of the father and family togetherness (Carty & Bradley, 1990; Yanover, Jones & Miller, 1976). A criticism of UK early discharge policies is that support programmes for mothers, which would facilitate early discharge from hospital, were not routinely introduced. Outside the UK early postnatal discharge programmes were carefully planned, implemented and favourably evaluated (Norr & Nacion, 1987).

Staff beliefs, workload and values may influence timing of discharge (Patterson, 1987; Hillan, McGuire & Reid 1997). Midwives who valued hospital postnatal stay were more likely to encourage women to remain in hospital longer. What is only superficially considered is the need for the nurse/midwife to cope effectively with early discharge and to meet the other realities of today's health care climate (Gillerman, Hicks & Beckham, 1991). Gillerman et al, (1991) said that although postnatal care should never be termed as routine, many of the same interventions, learning activities, teaching techniques and recovery milestones were part of every nurse-patient plan of care for the postpartum period. Identification and negotiation of the woman's learning and care needs are essential to individualised care. Ball (1994) highlighted that many aspects of postnatal care are at most a ritual with little sound basis for use.

1.3.5 Duration of stay in hospital

During the 1980s the standard duration of postnatal stay in hospital was reduced from 5.3 days in 1980 to 4.4 days in 1986 (Murphy-Black, 1989) and early postpartum discharges were actively encouraged (Van Wetzel, 1990). At this time the nature of community midwifery was changing, most maternity services were integrated, antenatal care provision was moving into the community and women were being offered DOMINO deliveries. The term DOMINO means 'Domiciliary IN and Out'. The midwife would carry out all antenatal care, be 'on call' for a period leading up to the delivery. She would deliver the woman in hospital; transfer mother and baby home around 6 hours

postnatally and continue to provide routine postnatal support. The advantage of this method was that the woman would have continuity of care, be delivered by a known midwife, but in an environment where help was at hand if required and following delivery could go home within six hours. Disadvantages of this system centred around its labour intensity. Midwives were on call for DOMINO's for at least two weeks before delivery. If called to a DOMINO this affected other elements of community care and impacted on the workload of other community midwives. The uptake of this service especially in Scotland was not good (Mansion & McGuire, 1998). There was no available evidence to explain why the uptake in Scotland was so poor; anecdotally midwives said that Scottish women were culturally different to women elsewhere in the UK. However, it now appears that, for a variety of reasons, including workload, many women were not given the choice of DOMINO (Hillan et al, 1997). The most recent audit of maternity care in Scotland questioned the need to continue offering women the option of a DOMINO delivery, especially as the emphasis is now on individualised midwife led care (Penney et al, 1999). The most recent available statistics highlighted that the mean hospital postnatal stay in 1998 was three days (ISD, 1999). The move towards early postnatal discharge reflects a change in attitude towards childbirth and outpatient care as well as declining fiscal resources (Lock & Joel, 1999).

There is little evidence to identify what constitutes a suitable length of postnatal stay in hospital. Economics, resources, maternal and professional views combined with the available evidence all impact on the outcome. Small et al (1992) concluded that shorter postnatal stays, particularly for women who choose them, are not disadvantageous and may be associated with significant benefits such as increased rates of breastfeeding. The notion that confidence is gained via access to expert advice at the hospital bedside is called into question by Small's study. Small highlighted that there is little evidence to support existing postnatal care and although midwives work on assumptions that hospital care is good, for many women it may be a source of anxiety and stress. Assumptions were made about the value of hospital postnatal care in terms of education and support for the new mother, yet studies such as the

Audit Commission (1997) are critical of the poor education, support and care given to new mothers in hospital. Small et al advocated the involvement of women in the decision making process antenatally and suggested that parentcraft education should incorporate and reflect this.

Midwives and other maternity care professionals cite women's choice as a reason for prolonged stay in hospital yet there are no corresponding choices offered to patients in the acute sector, nor is there any evidence to support this view (Walsh, 1997). Midwives must consider carefully the individual needs of each woman and avoid using routine observations as a ritual. No evidence exists that a longer stay in hospital with routine ward postnatal examinations, reduces morbidity or aids the transition to motherhood or increases breastfeeding success rates (Henschel & Inch, 1996; Cleutt, Alexander & Pickering, 1995; Renfrew & Lang, 1994; Cleutt, Alexander & Pickering, 1997).

With the average length of postnatal stay in hospital reducing annually, it is not surprising that previously accepted terms such as 'early postnatal discharge' are now ambiguous. Early postnatal discharge can take place at any time following the birth but the usual interpretation of early postnatal discharge is up to 48 hours after birth. However, internationally early postnatal discharge is likely to be within 24 hours of birth. Typically, those suited for early postnatal discharge are described as low risk (Thurston & Dundas, 1985).

Professional priorities and expectations are likely to impact on decision making to support issues such as time of discharge. In a recent study in the USA, research was conducted to investigate how nurses and physicians use an extra day of hospitalisation to care for the women (Margolis & Kotelchuck, 1996). The study highlighted that between professional groups of women there was a marked difference between risk factors and timing of discharge. Midwives saw education and attendance at childbirth classes as a crucial criterion for early discharge whilst doctors were concerned about social issues such as lack of high school education, no insurance, inadequate prenatal care

as the factors likely to influences decisions about postnatal discharge. The study highlighted that in spite of intense pressures to discharge early midwives were more aware of potential risk and morbidity when making decisions about discharge. This study supports others in highlighting that the quality and emphasis of care provided by midwives differs from physicians (Raisler, 1985; Buhler, Glick & Sheps, 1988).

Walsh (1997) postulates that women's expectations are that they will stay in hospital for a couple of days. Evidence highlights that dissatisfaction occurs when expectations are not met. If women are informed early of the advantages of early discharge some women may be satisfied to go home soon after delivery.

1.3.6 Impact of early postnatal discharge on outcome

There was a concern that the introduction of early postnatal discharge might increase maternal and infant mortality and decrease breastfeeding success. However, the Cochrane review considered the impact of early postnatal discharge on breastfeeding and concluded no adverse effects on breastfeeding rates was evident when women left hospital early (Renfrew & Lang, 1994). A study was carried out to compare breastfeeding rates after traditional hospital care versus early postnatal discharge and found no significant differences in either frequency or duration of breastfeeding amongst the groups (Kvist, Persson & Lingman, 1996). However the groups in the study had the option of choosing traditional or early postnatal discharge and this influenced findings.

Early hospital discharge is thought to reduce health care costs. However, it also decreases opportunities for women to learn the mothering role with help from maternity care providers (Brown & Johnson, 1998). Although the neonate may be more at risk of infection in hospital, there are concerns that if women and their babies are discharged from hospital too soon after delivery, they may not have appropriate knowledge about caring for the baby. Young (1996) highlights that mothers may not recognise potential problems such as dehydration and jaundice in their babies. Research has not produced a

definitive answer to the question of length of postnatal stay or the consequences of early postnatal discharge (Margolis, 1995; Rush & Valantis, 1992). However, in spite of available evidence, clinicians continue to discharge women and their babies earlier. An American study by Brown & Johnson (1998) which introduced follow up care to new mothers and their babies at home established that home follow up can provide a cost effective method of care in the first six weeks after birth.

A retrospective before-after cohort study involving 7009 infants born by uncomplicated vaginal delivery between 31 December 1993 and 29 September 1997 was conducted in Canada. The primary outcome was a comparison of the rate of hospital re-admission among newborn infants before and after an early discharge policy was implemented. The causes for re-admission were secondary outcomes. Findings of this study highlighted that 11.7% of the early discharge cohort as opposed to 6.7% of the pre-guideline cohort required re-admission by one month (odds ratio 1.86, 95% CI 1.51- 2.30). The study established the main reason for re-admission was neonatal jaundice and concluded that decreases in newborn length of stay may result in a substantial increase in neonatal morbidity (Lock & Joel, 1999). The early discharge programme in this study resulted in a reduction of inpatient stay from a mean of 2.25 days to 1.62 days ($p < 0.001$). Care providers should take cognisance of this study as it highlights the dangers of further reduction in postnatal stay for 'well' women and their babies.

1.3.7 Evaluation of early postnatal discharge programmes

It appears from the literature that the longer inpatient stay was used to observe and support new mothers. Little evidence is available of the effectiveness of this (Garcia & Marchant, 1996; Ball, 1987). In many instances the thought, planning and evaluation involved with the introduction of early postnatal discharge programmes was minimal. Little consideration was given to the midwives and the role they should play in such a system. Patterson (1987) highlighted the paucity of available literature regarding the stresses, frustrations and difficulties that nursing/midwifery staff encounters in trying to meet the teaching and care needs of these women. The consequences for the

midwife include new patients every day resulting in a new process of caring each day and leading to lack of job satisfaction and unease (McGregor, 1994). McGregor (1994) argues that the introduction of follow up telephone calls and postnatal home visiting are essential to a quality service.

The early postpartum period is one where many women feel isolated and anxious. As a result of fragmentation of services, shortened postnatal stay in hospital and fewer family supports, many new mothers need a source of advice and support. Evidence suggests that many postnatal women telephone the maternity ward for guidance after discharge (Rush & Kitch, 1991). For many women the postnatal ward is the preferred option, as women know that midwives are always there. The superiority of longer postnatal hospitalisation in facilitating improved outcomes has not been established and arguments that continued hospitalisation poses increased risk are equally tenable (Britton, Britton & Beebe, 1994). Regardless of the limited evidence health providers throughout the UK are taking steps to reduce the number of maternity beds and increase the number of births per bed per annum (GGHB, 1999).

The majority of work related to early discharge programmes has been carried out in the US and many of these have been positively evaluated (Norr & Nacion, 1987; Berryman & Rhodes 1991; Carty & Bradley, 1990; Welt, Cole, Myers, 1993). In Sydney, Australia, a study to evaluate planned early discharge home established that there was no increased morbidity associated with the early discharge group. The study recognised that continued postnatal domiciliary surveillance reduces the risk that early neonatal problems be overlooked (James, Hudson, Gebski, Browne, Andrews, Crisp, Palmer & Beresford, 1987).

Evaluation of early postnatal discharge programmes is difficult. There is limited evidence of the use of RCTs. Patterson (1987) compared postpartum early discharge with traditional groups using voluntary selection. Low risk mothers who voluntarily selected early discharge were compared with mothers who met the criteria for early discharge but who chose to stay in hospital longer. (Definition of early discharge was less than forty hours after birth).

The findings indicated that those who requested to stay in longer were asking for nursing support, knowledge about infant care and rest. The women who were discharged home early were more satisfied with their home visits and their ability to care for their baby. This suggests that a more intensive home visiting programme may be more effective than a longer stay in hospital. In the USA, many of the early discharge programmes emphasise education for parenthood as a necessity (Norr & Nacion, 1987).

In one of the few RCTs on early postpartum discharge Carty & Bradley (1990) identified that mothers in the early discharge groups were significantly more satisfied with their care than those who remained in longer. More early discharge mothers were breastfeeding at one month and those hospitalised longer scored higher on measures of depression and lower on confidence scores. However women who were discharged within twelve to twenty four hours following a normal delivery had five follow-up visits within ten days. The suggestion was that home visits by the nurse/midwife enhanced the woman's confidence in her mothering role. In 1987, Waldenstrom, Sundelen & Lindmark carried out an RCT in which women were randomly allocated in late pregnancy to early or routine postnatal discharge. The study concluded that there was no statistical difference in terms of infant and maternal morbidity between the groups.

1.4 Recent Policy Developments And Their Influence On Postnatal Care Provision

The 1960s and 1970s saw the increased medicalisation of childbirth. Policy developments were based on assumptions that the decline in perinatal mortality was primarily due to the increased number of hospital births and hospital was the safest place to give birth. These assumptions, although now largely refuted, were then readily accepted (Tew, 1995; Matthews, 1995). By the 1980s some of the changes in philosophy and management of maternity care were being questioned. Consumers and midwives began to question the need for a medically dominated system of care (Reid and Garcia, 1989; Bostock, 1993; Page, 1995). Childbirth became increasingly medicalised and only considered normal in retrospect. Increased medical intervention placed

further demands on NHS resources. Investigation of postnatal care in the UK went almost unheeded until the work of Ball (1987) highlighted that while the postnatal period was a crucial time in the transition to motherhood, midwives tended to adopt a blanket policy of postnatal care for all women. Midwives gave little thought to the individual needs of women. They seemed to blindly follow a pattern of daily postnatal visiting until the UKCC changed its guidelines on this in 1986.

In the early nineties a review of the maternity services resulted in the production of policy documents aimed at improving maternity services (SOHHD, 1993; DOH, 1993). Based on the evidence made available to them, the English document Changing Childbirth and its corresponding Scottish document made similar recommendations about maternity care. Both reports (DOH, 1993; SOHHD, 1993) highlighted that postnatal care was the most poorly evaluated element of maternity care and emphasised the need for the three 'C's' (Choice, Continuity, Control) in the provision of maternity care. The reports suggested that maternity care should be woman centred rather than based on a medical model.

In England, but not Scotland, pump priming funds were made available to introduce and evaluate innovative new patterns of postnatal care. Many new models of care, which involved more intensive care by the midwife, were implemented without evaluating existing patterns of care. Little cognisance was taken of women and midwives' views of existing facilities or care options. In a recent study midwives acknowledged that they sometimes omitted to offer women care options such as DOMINO as these options had added work implications for them (Hillan et al, 1997). Not surprisingly problems including midwifery burnout occurred as a result of introducing models of care which increased workload, added to stress, changed working patterns and effectively the personal life of midwives (Sandall, 1997).

1.4.1 Implications of policy developments on postnatal care

Many reports including the Scottish Policy Review (SOHHD, 1993) were critical of hospital postnatal care, resulting in statements suggesting that

inpatient postnatal stay should be reserved for 'ill' women or babies, while low risk women should be cared for in their homes (SOHHD, 1993). The Scottish report suggested the economic savings that would be associated with earlier postnatal discharge and more community based postnatal care. However Twaddle, Liao, & Fyvie, (1993) caution that economic savings may not be as high as anticipated.

Many health care professionals were concerned that attempts to improve the standard and quality of postnatal care were made without proper evaluation of existing services. Studies began to highlight the limitations of the postnatal care provision and women expressed dissatisfaction with the system (Hillan, 1991; Ball, 1987; Lothian Health Council, 1992; Lothian Health Council, 1992; Reid & McMillan, 1992; Bostock, 1993). As a result of Changing Childbirth (DOH, 1993) and the Provision of Maternity Services In Scotland: A Policy Review (SOHHD, 1993), continuity of care became a priority for maternity services. The drive to achieve continuity of care occurred without due thought to the concept of continuity of care (Fleissig & Kroll, 1997). The rationale behind advocating continuity of care centred on the need to avoid confusion and conflicting advice for women in the postnatal period. In many instances the term continuity of care and carer were taken as synonymous. It is now accepted that continuity of care can be achieved without necessarily having continuity of carer.

> *"Continuity of care implies that women receive consistent care and advice from midwives who are familiar with the woman's history, wants and preferences through pregnancy, birth and into the postnatal period. Continuity of carer implies that such care and advice are provided in the main by one midwife."*
>
> (Stock & Wraight, 1993)

In many instances the continuity of care available antenatally and during labour often comes to an abrupt halt postnatally, especially after discharge from hospital and new mothers may be sent home with minimum advice and direction (Nolte, 1992). Many reports, although advocating continuity of care, acknowledge that it is a difficult concept to achieve in practice (DOH, 1993; SOHHD, 1993). Attempts to reduce fragmentation of care included changes in the organisation of care such as, DOMINO, team midwifery, birth plans, the

use of models of midwifery care (Murphy-Black, 1992). Reports such as Changing Childbirth (1993); SOHHD Policy Review (1993) and The Maternity Care and the New NHS Report from the Presidents of the RCOG & RCM and Chairman of RCGP, (1992), all stress the importance of continuity of care and carer and endorse the above recommendations. Recent evidence suggests that women are more concerned with continuity of care than carer (Rennie, Hundley, Gurney & Graham, 1998; Fellowes D, Horsley A, Rochefort J, (1999). Women want to trust and have confidence in their midwife and may not necessarily want to "know" the midwife. However, many midwives find themselves in positions where they are offering systems of care which reflect consumer expectations without any recognition of the needs of the midwife (Fleissig & Kroll, 1997). Midwives find these demanding models of care difficult to sustain and ultimately this can affect job performance and satisfaction (Sandall, 1997).

1.4.2 The developing role of the community midwife

Priority is now given to providing midwifery care in the community. Traditionally the end of the puerperium has been marked by the six-week postnatal examination carried out by the General Practitioner. Recently the value of this examination has been questioned and evidence suggests that the traditional format should be amended to include more specific questioning in order to identify postpartum morbidity (Bick & MacArthur, 1994). The findings of this study would suggest that it is appropriate for the community midwife to participate in the six-week postnatal examination especially as she has been the major care provider during the postnatal period. But, opposition to this comes from three quarters – the midwives themselves who see it as extra work and the General Practitioners and Health Visitors who may feel threatened by the way in which midwifery practice is developing.

1.4.3 Organisation of postnatal care in other countries

Not all countries have a National Health Service which covers the cost of maternity care. Many countries depend on private health care insurance to finance medical, nursing and hospital fees. In many instances private insurance either does not fund, or offers minimal support for, maternity care.

Because of this many women leave hospital shortly after the birth of the baby rather than incur large hospital fees.

Professionals in countries such as Australia and parts of North America responded to increased demands by organisations and health insurers to reduce the length of hospital postnatal stay, by developing early discharge programmes (Waldenstrom, 1987; Welt et al, 1993; Yanover, 1976; Zwergel & Ende, 1989). In other countries where private health care is required to fund hospital postnatal stay; women are discharged within forty-eight hours without any support system in place. The frustrations felt by obstetric nurses (as they are called in the USA) and the concerns of many mothers, resulted in the introduction of a domiciliary role for nurses caring for these women. In a North American study, James et al (1987) found that women who were discharged early with 'nursing' support had a more favourable adjustment to the postnatal period. The study also highlighted that continued postpartum surveillance increased the chances of identifying neonatal problems. Many hospitals that discharge postnatal women early introduced assessment tools for the home visit nurses to use. Zwergel & Ende (1989) found that one intensive visit by a nurse the day after discharge can play a significant role in supporting a family's transition into parenthood. In any system of care it is helpful if the woman has met the professional who will visit her beforehand and this appears to be integrated into most of the early postnatal discharge programmes in the USA (Jasson, 1985).

Postnatal care in Europe tends to be restricted to hospital care. If the woman is to be visited at home it is likely to be by a care assistant in the Netherlands (Mander, 1995). In other European countries there may be one postnatal visit (not necessarily from a midwife) to complete the Guthrie test.

1.5 Conclusion

Historically, midwives have been the health care professionals most consistently involved with the support and care of postpartum women and their babies. The intervening years since the first Midwives Act has seen changes in the focus, organisation and delivery of postnatal care. Good

postnatal care minimises and may prevent varying forms of morbidity to mother, baby and the family in general.

Uterine haemorrhage and puerperal sepsis accounted for a high proportion of maternal mortality and morbidity in the first part of this century (Loudon, 1986; Loudon, 1987; Loudon 1992). The Central Midwives Board detailed specific responsibilities, observations and routines that should be carried out by the midwife in an attempt to reduce mortality and morbidity (CMB, 1919). Although the background to the postnatal examination is unclear it is probable that the tasks, which formed the postnatal examination, were linked with identifying postnatal morbidity. Eventually these observations and routines were incorporated into the statutory instruments which regulated midwifery practice (Murphy Black, 1989). The provision of appropriate care, support, education and assistance to facilitate recovery from childbirth and the transition to motherhood is identified as the main purpose of postnatal care. The Midwives' Code of Practice (UKCC, 1998) describes the activities of a midwife and included in this is a specific mention of activities in the postnatal period

> *"to care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant."* *(UKCC, 1998)*

Questions continue to arise concerning the most effective ways of organising the postnatal service and research evidence about the effectiveness of clinical components of postnatal care is limited (Garcia & Marchant, 1993). Although the routines of postnatal care were vividly described and questioned by Ball, (1987) it seems that much of the existing postnatal service is based on routines with added selective elements (Garcia & Marchant, 1996).

In the UK postnatal care includes hospital and community care. The evidence highlights that hospital care is traditionally poorly evaluated and does not meet women's needs and expectations yet little has been done to rectify this (Penney et al, 1999). The move towards discharging women earlier may have been considered the answer but systems were not in place to fill the void identified by women. Although much of the debate about postnatal care

centres on the organisation and provision of services, a reduction in the length of stay in hospital should not be considered in isolation. Support mechanisms such as the introduction of twenty-four hour telephone helplines would provide the woman and her family with constant support if required (Rush & Valaitis, 1992).

For many women postnatal hospital care was an important part of the culture of childbirth (Mansion & McGuire, 1998). Anecdotal evidence suggests that many midwives were opposed to early postnatal discharge because they felt women need the attention and support available in hospital, yet the evidence suggests that women do not get the support and education they need whilst in hospital (Audit Commission, 1997). Midwives fear that early postnatal discharge will create more work, stress, less job satisfaction and that maternal and neonatal morbidity may increase. In countries that do not have a generic state health system women are discharged from hospital much earlier than in the UK. International research evidence suggests that well planned and implemented early discharge programmes together with adequate antenatal preparation and postnatal domiciliary visits does not adversely impact on outcome (Kvist et al, 1996) and may have more positive outcomes than a longer stay in hospital. However UK evidence to support this is not available and work must be done to complement similar international studies.

It is now widely recognised that appropriate postnatal support by health care professionals is critical in helping maternal readjustment following childbirth (Henderson, 1997). However, irrespective of the paucity of available evidence postnatal women continue to be discharged from hospital earlier (Bick et al, 1997). It is essential that midwives be in a position to provide the optimum care and support for postnatal women. This involves an insight into the evidence on which the midwife bases her practice and an ability to evaluate that practice objectively. The mid 1990s saw a rise in the profile of postnatal care, partly due to the evidence which highlights the levels of postnatal morbidity (Glazener et al, 1995; Bick & MacArthur, 1995). Examples of initiatives to inform and enhance postnatal care are:

- The comparison of current care with protocol based midwifery-led care beyond twenty eight days (Bick et al, 2000);
- Trials to compare different interventions postnatally e.g. postnatal support group and postnatal booklet (Reid, Glazener, Murray, Taylor, 2000);
- Comparisons of current midwifery postnatal visits with a combination of midwife and community support worker (Morrell, Spiby, Crowther, 2000).

Hospital postnatal care is consistently poorly evaluated and postnatal morbidity remains high (Audit Commission, 1997). Concerns exist that midwives may have lost some of their key decision making skills. There is no available evidence to inform professionals about whether midwives are able to discriminate between women who need a visit and those who do not. Maternity services must be sensitive to the changing needs and priorities of women and their families and respond accordingly. The following Chapter will develop the issues/themes identified in this chapter and relate them to the midwives' role in the provision of postnatal care.

CHAPTER TWO

MIDWIVES AND THE PROVISION OF POSTNATAL CARE

Integral to the delivery of quality postnatal care is a midwifery workforce, which is skilled and capable of delivering the care, support, and education that women need and expect. The previous chapter described the development of postnatal care in Scotland and this chapter will address the part that midwives play in the delivery of maternity services; in particular, postnatal care. Many changes have occurred within maternity care in the past decade. The perceived rationale for the changes, the ways in which they were evaluated and the impact that the changes had on midwives and the way they work will be explored. Many of the studies to implement and evaluate new models of care focused on client satisfaction. In order to ensure a successful and achievable outcome in the development and implementation of any element of maternity care it is important to include midwives as part of the research process. It is also necessary to consider the long-term impact that the proposed changes will have on the service.

The medicalisation of childbirth combined with an increased emphasis on antenatal care resulted in the postnatal period being perceived as having low status and dubbed the "Cinderella" of the maternity services (Ball, 1987). The mid 1980s saw a questioning of the role and function of midwives in the delivery of postnatal care. It was argued that medical dominance hampered the way in which hospital postnatal care was organised and delivered (Rider, 1985). During the 1980s there continued to be considerable focus on physical care and limited attention to information giving, education and emotional support and research in the postnatal period (Robinson, 1985; Rider 1985; Ball, 1987).

2.1 The Midwifery Workforce In Scotland

The demographics of the midwifery workforce in Scotland impact the maternity care options available to women. Midwives should be able to offer the variety of models of care recently advocated. Almost 50% of the midwifery workforce in Scotland works part time. The average midwife is

thirty-nine years old and has practised as a midwife for almost twelve years. For midwives the Scottish Policy Review, (1993) brought with it changes in responsibility and accountability (Hillan et al. 1997). The facilitation of choice, continuity and control for pregnant, labouring and postnatal women (SOHHD, 1993) implicitly suggests that a different approach to service care provision must be taken.

Community postnatal care is traditionally the domain of the midwife but midwives are encouraged to work collaboratively with doctors and obstetricians in an attempt to provide individualised care for women. The UKCC recognises that in the changing health care environment midwives must be aware of their professional accountability. Graham (1997) argues that while the interrelationships between women and providers of care show signs of improving, the same cannot be said for the partnerships between the complementary providers of maternity care. Midwifery skills should be identified, acknowledged and channelled towards the aspects of the service they are designed for (The Scottish Office, Acute Services Review, 1997-1998). In caring for postnatal women in their own homes, midwives rely on a variety of skills, experience and clinical judgement to support and care for the woman and her baby, yet little emphasis is placed on identification and development of these skills.

The demographic picture of midwives in Scotland suggests that it may not be feasible to offer care options which involve long 'on call'1 commitments for midwives. Demographic issues such as age, full or part time status and family commitments all appear to influence midwives' decisions to join new templates of care. The part time nature of the midwifery profession in Scotland does not bode well for the introduction of new labour intensive models of woman centred care (Hillan et al. 1997).

2.1.1 Traditional models of maternity care In Scotland

Typically the provision of maternity services in Scotland has been fragmented. The geography and socio-economic aspects of the country combined with the increased medicalisation of childbirth all influences how maternity care is

delivered to women. In consultant led units (of which there are twenty-three) the delivery of maternity care tended to be hospital based and followed a medical model. In the past decade services began to move into the community and visits to hospital-based clinics were less. Midwives became more involved with the provision of holistic care and there was a groundswell of feeling that midwives should take responsibility in caring for low risk women (SHHOD 1993, McIllwaine, Cole, Twaddle, 1994). Midwife led units were set up and evaluated (Turnbull, McGinley, Fyvie, Holmes, Johnstone, Cheyne, Shields & McLennan, 1995; Hundley, Cruickshank, Milne, Glazener, Lang, Turner, Blyth & Mollison, 1994). Latterly team and group practice midwifery schemes were set up although in some instances these schemes did not include community postnatal care. Today, although midwifery led units still exist; the throughput of women using this service is much less than anticipated (Penney et al, 1999). Reasons for the poor uptake of this facility are unclear. It may be that the women do not know about it, or rigidity of protocols for admission and remaining in the unit (Penney et al 1999).

2.2 Midwives And Postnatal Care

The previous chapter addressed the issues central to the delivery of quality postnatal care. It identified gaps in evidence and practice whilst at the same time highlighting a mis-used potential. Postnatal care has traditionally been the area of maternity care offered almost exclusively by midwives and yet this is the area most commonly criticised by women (Audit Commission, 1997). Midwives are sometimes constrained in their care delivery by routines and procedures involving other health care professionals. For instance, a paediatrician must examine each baby within twenty hours of delivery and again prior to discharge. If midwives are dependent on the paediatrician to complete the first or discharge examination of the baby, women may have to wait sometimes for long periods, (especially in smaller units) until the paediatrician is available. Recently early discharge from hospital and increased workload in other areas of maternity care such as antenatal care has influenced the delivery of postnatal care. Community midwives find that increased workload antenatally impacts on the time midwives can spend on postnatal care.

2.2.1 *Decision making in midwifery*

Essential to the provision of woman centred postnatal care is the ability of the midwife to individualise care and make critical decisions about the amount, timing and content of the postnatal visits. Many believe that the hospital model of care has resulted in a de-skilling of midwives, resulting in an inability by many midwives to offer the same care and expertise in all spheres of midwifery practice (Hillan et al, 1997). As stated in the previous chapter the medicalisation of childbirth had consequences for the midwifery profession and was associated with the hospitalisation of childbirth which increased after the foundation of the NHS (Symonds & Hunt, 1996), it resulted in many midwives deferring to doctors for decisions about care (Tew, 1995). Symonds and Hunt (1996) highlight that the medical profession has always operated a demarcation strategy in respect of midwifery and obstetrics. The strategy adopted was one of de-skilling midwifery but preserving its status as an independent occupation (Witz, 1992). Consequently for many midwives the gradual decision making and clinical de-skilling also brought about an associated loss of confidence and an acceptance that the obstetrician was the 'lead clinician' irrespective of risk.

Little is known about how community midwives allocate their time between mothers. Indeed community midwives undertake a wide variety of tasks during home visits, not always matched to a mother's own perceived needs (Murphy Black, 1989). The changing focus of maternity care combined with organisational changes has resulted in a shifting of the responsibility for maternity care. All pregnant women in Scotland are under the care of a named obstetrician. This is not necessarily the case in England. This may be because 98.8% of deliveries in Scotland take place in hospital. Of the remainder, 0.3% and 0.8% are home birth and DOMINO deliveries respectively (Penney et al, 1999). Staffing and organisational issues have influenced the amount of women who are offered DOMINO delivery (Hillan et al, 1997). These figures raise concern about the skill base of community midwives. In areas where team midwifery is in place, midwives will have the opportunity to maintain their skills in all aspects of midwifery care, but midwives who are based solely on the community may not be so fortunate. Failure to maintain essential

midwifery skills may lead to loss of confidence and impact on other areas of midwifery care.

Community midwives work closely with General Practitioners and this may impact on the decision-making strategies they utilise. Midwives may have lost or failed to acquire the crucial decision-making and organisational skills required to practise autonomously. In a recent study some midwives admitted that they had lost key skills. However, they did not appear concerned about this and argued that skills could quickly be developed and enhanced if required. Midwives identified clinical skills related to labour or neonatal intensive care as those most likely to need upgrading (Hillan et al, 1997). This suggests that midwives either see postnatal care skills as generic or view postnatal care as an area of lesser priority. Evaluation of postnatal care suggests otherwise. It may be that midwives' perceived priorities in delivery of postnatal care do not match women's requirements of postnatal care, culminating in a poorly evaluated service. In order for midwives to deliver quality postnatal care they must be able to identify the needs and priorities of individual women and then use their knowledge and skills to meet these needs.

2.2.2 Problems in implementing new models of care

Many pilot schemes for the provision of woman centred care are being wound down and there is little evidence that examples of good practice are being integrated into mainstream midwifery provision (Kaufmann, 1998). The argument exists that in spite of, or indeed to spite, Government policy and research evidence there has been little impact on clinical practice (Kaufmann, 1998). Midwives delivering postnatal care and in particular community postnatal care do not necessarily see this service as being at the cutting edge of maternity care. Consequently, not enough emphasis has been placed on postnatal care, resulting in dissatisfied women and partners and an increased chance of problems arising. Postnatal care provision tended to react and respond to other elements of maternity care provision. For example a reduction in maternity beds resulted in earlier postnatal discharges, more women needing care in the community, leaving midwives with less time to support new mothers and their babies. Consequently women were discharged

still earlier. However, the basic issue of how best to create a supportive and facilitative care environment in the postnatal ward was never really addressed (Jackson, 1996). Whilst these changes were occurring, and in direct response to the Policy Review (SOHHD, 1993), community midwives found themselves with an ever increasing workload without a corresponding increase in manpower.

In the early 1990s important changes occurred in the education of student midwives. Three-year direct entry programmes were introduced, there was a reduction in the number of student midwives in Scotland and the Health Boards no longer paid them. The position of student midwives who had been an important part of the workforce altered almost overnight, yet no work has ever been done to consider the impact of this on the delivery of maternity services in Scotland. Highlighting the importance of postnatal care provision rather than considering it merely as an appendage to maternity care may encourage midwives to reflect on their care and the skills they utilise postnatally. Given that there is increasing concern about the levels of morbidity experienced by women after childbirth (Glazener et al, 1995), it is appropriate to question, evaluate and amend the existing care in an attempt to improve quality and outcomes.

2.2.3 Midwives satisfaction with the care they offer

Successful delivery of high quality care will only be achieved by a workforce which is knowledgeable, motivated and satisfied with the care it delivers. Although many studies have considered consumer satisfaction with maternity care, few have established the impact on midwives and their levels of satisfaction with the care they offer (Turnbull, Reid, McGinley & Shields, 1995; Hundley, Cruickshank, Milne, Glazener, Lang, Turner, Blyth & Mollison, 1994). The most important predictor of midwife satisfaction was autonomy and conversely the most important factor in midwife dissatisfaction was medical staff involvement (Hundley et al, 1994). Dissatisfaction occurred when there was lack of trust in the midwife's judgement (Hundley et al, 1994), resulting in midwives' lack of confidence which tends to occur when other professionals take on aspects of the midwives' role (McCrea & Crute, 1991).

Those studies that included midwifery satisfaction as a component also highlighted that the midwives who were recruited for new schemes of care were not typical of all midwives (Turnbull et al, 1995; Page, 1995; Hundley et al, 1994). A comparison cannot be made between midwifery satisfaction with different models of care inasmuch as involvement of the midwives differed markedly from model to model. The success of any innovative model of midwifery care depends to some extent on the midwives' attitudes to their professional role and whether or not they enjoy working in the new system of care (Wraith, Ball, Seccombe & Stock, 1993). Turnbull et al, (1995) established that if change were managed in a systematic manner, it is possible to increase midwives professional satisfaction, while at the same time minimising any negative effects, such as increased stress.

Care options which increase continuity of care antenatally and postnatally and reflect the needs of women, do not seem to be as popular as options, which offer specific care for delivery. Perennial problems such as increased workloads coupled with understaffing, increased responsibility unmatched with real power and grading issues all serve to increase the tensions within the midwifery profession (Kaufmann, 1998). The impact of recent changes in maternity care provision on the midwife's role in the delivery of postnatal care has yet to be clearly identified.

2.2.4 Midwives and the acquisition of skills for the postnatal period

In order for midwives to be practitioners of normal birth, clinical skill acquisition must be complemented by professional freedom and self-governance (Lewis, 1998). Comparisons have been made between medical and midwifery knowledge. Fleming (1998) argues that midwives have a sound knowledge base but that this remains part of an oral culture: midwives pass on their experience and knowledge to fellow midwives and students verbally. However, this knowledge is not usually committed to paper, formally acknowledged and investigated in any way. While birth is now accepted as a social event, the medicalisation of childbirth in the seventies and eighties appeared to perpetuate the view that midwives were subordinate to

doctors. Instead of developing and enhancing skills in their own domain such as postnatal care many midwives sought to develop and utilise skills previously associated with the medical profession, for example, ventouse extraction and perineal repair. Although parameters of midwifery practice are no longer clearly defined, the literature is slow to highlight ways in which midwives have adapted to accommodate their new roles. Midwives seem to prefer practice based on experience (White, 1996), tradition, anecdotal evidence and personal preference (Hurley, 1998). There is a valid argument that midwives themselves may be the guardians and perpetrators of unsound traditional practices (Lewis 1998). Although midwives are beginning to question what it is they do, little evidence exists to demonstrate the professional judgement of midwives especially in the postnatal period. Lewis (1998) asserts that if professional judgement is worth nothing, then professional status and ability to influence practice has little validity. The UKCC Scope of Professional Practice (1992) states that the midwife must

> *"maintain and develop the competence which she has acquired during her training, recognising the sphere of practice in which she is deemed to be equipped to practise with safety and competence."* *(UKCC, 1992)*

Implicit in this statement is the need consistently to appraise and critically evaluate the care delivered to women. Part of this self-evaluation should include a review of the decisions made and the resulting outcomes. Midwives are challenged to account for their practice, to reason their decisions, and utilise critical thinking in the pursuit of excellence (Price, 1995a,b,c).

2.3 Clinical Judgement And Decision Making Skills

The skills required for clinical decision-making are complex and involve a sound foundation for the decision to be made, combined with knowledge of theories, clinical evidence and clinical experience. Today's midwife is described by Page (1995) as a professional clinician, who bases her practice on strong evidence, managing her own caseload and her own time, working in relationship with the woman and her family throughout the pregnancy both in hospital and community.

Essential to this is an understanding of the decision making process as used by midwives. Clinical judgements are dependent on the knowledge and experiences of midwives, and are part of the decision making process. Judgements of this nature are made after client/ patient information is gathered and evaluated (White, Nativio, Kobert et al, 1992). The two main approaches to decision making are prescriptive and descriptive. The prescriptive approach considers how decisions ought to be made (Hughes & Young, 1990) while the descriptive approach addresses how decisions are actually made by nurses and midwives (Benner, 1984; Jones, 1988). The nature of decision-making in midwifery means that midwives may have to assess complex situations involving many variables and uncertainties. Work, in the field of decision making in nursing, highlighted that nurses' decision-making processes are task dependent (Corcoran, 1986; Yocom, 1986; Corcoran, Narayan & Moreland, 1988;). The more complex the tasks are, the more likely the nurse is to take short cuts in reasoning in order to reach a conclusion. Midwives may exercise decision making in a similar manner calling up past experiences and knowledge to influence their decision. As experiences and knowledge impact on the decision, it is not surprising that decisions reached by individual midwives will differ from one another.

One investigation of the decision making skills of midwives found that midwives relied on heuristic processes in simulated clinical decision making situations and employed these processes to a greater extent the more complex the clinical case (Coiffi & Markham, 1997). Knowledge of the heuristic process should help clinicians, educators and researchers to consider how midwives reach decisions. The four classic principles identified with heuristics are:

- ***Representatives*** - midwives use this principle to judge the probability that certain signs and symptoms in women are indicative of a specific condition the midwife has met previously such as puerperal sepsis. In this instance the midwife would review her knowledge and experience of puerperal sepsis and carry out a risk assessment to establish other likely outcomes. Evidence from psychological and medical studies suggests that where the known risks of a condition are serious such as puerperal

sepsis or deep venous thrombosis, the incidence is overestimated (Bar Hillel, 1980; Balla, 1985).

- ***Availability*** - this principle is identified by the ease with which similar examples come to mind (Friedlander & Stockman, 1983; Coiffi & Markham, 1997). If the midwife recalls a similar example easily and vividly (such as a woman who had puerperal sepsis and then went on to become very ill and/or have a postpartum haemorrhage) then she is more likely to assess and treat the woman in a similar manner.
- ***Anchoring and Adjustment*** - these principles are identified when the midwife starts the decision making process from a specific point. For example, if a woman complained of feeling unwell and had a heavier than usual vaginal discharge, then the midwife would look at the woman's history to see whether she was at risk of puerperal sepsis. The midwife would adjust the diagnosis according to the history and clinical picture as it developed.

The more complex a situation the more likely a midwife is to use heuristic decision making processes. However, little is known about the varying levels of complexity on the use of heuristic processes by midwives in assessment situations (Coiffi & Markham, 1997). In order to gain insight into this, Coiffi and Markham (1997) completed a study which investigated the processes of clinical decision-making by student midwives in a simulated patient assessment situation. The findings suggested that midwives do use heuristic processes to inform their decision-making. 'Representativeness' was used most frequently in high and low complex cases. Midwives made decisions about practice, thereby hoping to make accurate decisions and save cognitive effort. As midwives use these specific skills it is essential that they constantly review and appraise their decision-making skills and outcomes of care. Furthermore, those midwives who are less experienced or have not been exposed to a specific condition may not have the necessary information to reach the right decision. Using evidence based practice supports midwives in the decision making process. Barwise (1998) argued that midwives use key ways to reach a clinical decision and break down the decision making process to a more simplistic format using four different approaches:

- The first, and more philosophical approach suggests that midwives identify the best action to achieve the desired goal. Implicit in this is the midwife's ability to assess and assimilate the information available to her.
- The second approach centres on the midwife's ability to judge a situation. Crucial to this decision is an understanding of the problem, her knowledge of the subject and her experience.
- The third approach is the ability of the midwife to reflect on her care and establish the critical elements of care that influenced the outcome. Criticism of this approach centres on the emphasis on the midwife using intuition (Price, 1995a). However, the experienced midwife draws on her experience and integrates this with her knowledge and professional standing to help inform the decision.
- The fourth approach explains that midwives use a logical approach, as the decisions become more important and irreversible, especially when they expect to be held accountable. In this instance the midwife has a thorough knowledge base and the ability effectively to rationalise and articulate her reasoning as well as being ultimately accountable for her practice.

Although the approaches identified may be adopted in isolation it is likely that a combination may be used. Other factors, which impact on the decision-making process, include personality type and autonomy. The personality of the midwife combined with her knowledge and experience will certainly influence decisions made. Klein, Gauthier & Robbins (1994) state that midwives with the highest rates of episiotomy are more likely to use other interventions as well. Although the midwife is deemed to be accountable and work as an autonomous practitioner many midwifery decisions and responsibilities are set within a hospital policy framework. In many instances the decisions and options open to her are set within a given framework. There is no doubt that informed and confident decision-making depends on the personality, knowledge, experience and ability of the midwife to critically evaluate options for care.

Midwives in situations of uncertainty take short cuts in reasoning as a way of simplifying complexities of the judgement tasks. The more complex the case the more the midwives rely on prior experience. Midwives tend to recall similar cases and behave almost in an intuitive manner. Fleming (1998) concurs that midwives *'come to know'* through experience and intuition and this is influenced by the context in which the knowledge was obtained. Although Fleming (1998) argues that the benefit of this knowledge is dependent on how the experience and knowledge is viewed, if seen in isolation to other issues, then a misinterpretation of the findings may occur. Benner (1984) acknowledged that intuition is an important component of the decision making process. The quality of this intuition is likely to be influenced by the professional's prior knowledge, experience and her ability to apply this appropriately.

In reality, midwives make a variety of decisions on a daily basis and the use of reasoning is essential to the decision. If midwives use prior experience to determine decisions, then the outcome will greatly depend on the appropriateness of prior experiences and the midwives' ability to recognise the experiences that have direct relevance (Coiffi & Markham, 1997; Barwise, 1998). Experience and knowledge of clinical effectiveness in community postnatal care will influence care delivery and outcomes. It follows that the more experienced the midwife is the more appropriate her decisions are likely to be (Coiffi & Markham, 1997). However, caution must be exercised regarding the degree of midwife reflection following the experience, and the quality, appropriateness and outcome of the experience. The apparent low status of postnatal care may influence the priority and attention that is given to it. In caring for postnatal women the limited evidence to support care and decisions may impact on the quality of care and the decision making process. It may be that midwives' knowledge structures are still entrenched in medical subordination and this impacts on the care they give women (Fleming, 1998).

Traditionally midwives reported any maternal abnormality to the doctor and instruction was given about the nature and content of routine observations

(CMB, 1936). Although the UKCC now issues much broader guidance (UKCC, 1998), many midwives continue to complete routine observations including the maternal temperature check without any evidence or justification for doing so (Marsh & Sargent, 1991; Takahashi, 1998). In their study Marsh & Sargent (1991) found that 715 of 783 postnatal visits involved a physical examination of the mother, even though this prolonged the visit by up to 25%. March & Sargent (1991) concluded that the apparent concentration of midwives on physical care of mother and baby supported Murphy-Black's findings (1989) and suggests that the tasks may be more a reflection of the midwives' perception of need rather than the mother's. In a systematic review of the literature Takahashi (1998) concluded that routine maternal temperature check in the puerperium has limited value as a screening test. She did however acknowledge that a large-scale study is required to evaluate this practice. The literature abounds with evidence of routine postnatal procedures and investigations which have become part of a routine without any clinical justification or evaluation of their role (Ball, 1994; Montgomery & Alexander, 1994; Marchant & Garcia, 1995).

2.3.1 Professional judgement and postnatal visits

Knowledge, experience and intuition support the professional judgement exercised by midwives (Hamilton, 1998). In practice, other factors can influence decision-making skills. The basis for decisions about postnatal visits are related to the health and well-being of the mother and baby, coupled with staffing and workload issues and the day of the week (midwives were less likely to visit women at weekends). Midwives acknowledged that 'extra duties which they have taken on' and the accepted practice that weekends are a time when visits are unlikely to occur all influence the pattern of postnatal visits. Hamilton (1998) argued that midwives lacked any dependable foundation to assess a woman's ability to identify when or if assistance is required. Many midwives base their decisions about the timing of a postnatal visit on a variety of factors some of which are only indirectly related to the mother and her baby. What midwives have been unable to identify clearly was the rationale for visiting and not visiting. In choosing not to visit, a midwife must consider a variety of factors including whether or not the

woman has the necessary skills and knowledge to identify when help or advice is required. It may be that the decision to omit or defer a visit involves a much more complex set of decision-making skills and requires a much better knowledge of the woman than the decision to visit.

Childbirth now requires a more complex approach to the delivery of maternity care. The relationship between mother and midwife provides a context for the use and development of high-level clinical skills (Page et al, 1997). Incorporated in this, is the use of clinical judgement, making appropriate clinical decisions, comforting and alleviating pain and distress, counselling, advising and teaching and providing hands on care. The consequences of the midwife's attitude and decision-making skills in postnatal care have long-lasting effects for the woman. If decisions reached by the midwife are made in isolation and fail to include knowledge of the woman then unfortunate consequences may result. Page et al (1997) suggests that knowing the woman influences some clinical decisions and makes them easier.

2.4 Midwife/Woman Relationship Postnatally

One of a midwife's key concerns is the promotion of emotional and psychological well being postnatally. This complex role involves knowledge of the biological and social sciences as well as knowledge of the midwife client relationship (McCrea & Crute, 1991). Certain studies have highlighted the woman–midwife relationship and debate centres on 'good' and 'poor' relationships. Midwives argue that the quality of a midwife-woman relationship is not associated with the length of time that the midwife knows the woman (McCrea & Crute, 1991). Midwives felt that a woman's trust and confidence in the midwife promoted good relationships (McCrea & Crute, 1991), a view supported by women (Rennie et al, 1997). Although women highlight the postnatal period as a time when additional support is needed, changes to other aspects of the community midwife's role may have resulted in less available time to provide this support. In spite of consumer criticism of postnatal care, little improvement has been made in postnatal care provision or outcomes. Until recently little emphasis was placed on the woman's

knowledge of the midwife yet the literature suggests that women have lasting memories of midwives they encountered (McCrea & Crute, 1991).

2.5 Midwifery In Transition

It is only in recent years that there has been recognition of the need to reflect and consider the factors that influence clinical decision-making by midwives (Coiffi, 1998; Barwise, 1998; Price, 1995b,c). Traditionally, midwifery education highlighted medical models and protocols of midwifery care. Midwives were urged to follow protocols usually set by doctors and little cognisance was taken of the pathway required to make clinical midwifery decisions. In the 1970s and 1980s midwives constantly deferred to obstetricians and even to house officers on obstetric secondment (Tew, 1995). Few midwives questioned the decisions of doctors, and even if they did, felt ill equipped to argue and support their case. Midwives were used to letting doctors make decisions and take responsibility for care. As the years went by, midwives began to question their role and skills. Although the maternity care environment was changing and recognition was given to the midwife's role (SOHHD, 1993; DOH, 1993; Audit Commission, 1997, Penney et al, 1999), midwives found themselves without sufficient evidence to support their case. Only 12% of midwifery clinical management decisions are informed by sound evidence (Page, 1996), years of medical dominance meant that midwives did not have the evidence to argue their case. Postnatal care has always been the domain of the midwife and consequently has little evidence to support its effectiveness.

2.5.1 Autonomous practice

The concept of autonomous practice is accepted as integral to community midwifery practice. However, it is argued that the midwife is rarely free to make decisions based purely on her own judgement (Barwise, 1998). Indeed, Mander, (1995) proposes that:

> *"structural autonomy implies the hierarchical or bureaucratic organisation within which most midwives practice, inevitably limits and constrains their freedom to make decisions".*

Midwives are required by statute to be competent at the point of qualification. Yet competence may not equate with experience, hence the need to support and guide inexperienced midwives through the professional pathway. In the same way new practitioners must be aware of the education and practice requirements needed to ease the transition from inexperienced to experienced midwife (Coiffi, 1998). The postnatal care sought by women suggests that a deeper knowledge and breadth of skills is required.

2.5.2 How midwives' attitudes impact on postnatal care provision

The argument exists that although interest is shown by Government in the cost effectiveness of midwife managed care and the alliance between consumers and midwives, it may well be that professionalisation of midwives will occur at a cost of dividing the midwifery workforce (Sandall, 1995). Although midwifery is female dominated, care must be exercised to avoid the assumption that women will give the best care to women.

Midwives want to feel needed by women (McCrea & Crute. 1991), and the concern that midwives may alter their care in order to feel needed may be a valid one. This may imply professional insecurity, or, implicit in this debate may be the recognition that midwives are the professionals capable of providing women with the guidance, support and confidence they require. McCrea & Crute (1991) argues that threats to confidence and self-esteem may be complicated by the issue of recognition of authority/autonomy in practising the midwife's role.

2.5.3 Midwives and the management of change

If change is managed well and systematically introduced, the end result may increase professional satisfaction, and at the same time may minimise any negative effects, such as increased stress (Turnbull et al, 1995). Given that change is almost constant within the health service, it is important to recognise the theories and models of change. Marris (1986) compares and contrasts change to bereavement. She argues that loss and change disrupt our ability to find meaning in experience, and it is in periods of recovery that individuals attempt to give meaning to the present. Thus in midwifery practice, midwives

faced with change may feel a loss for the old way of doing things and a reluctance to change. In 1990 Isabella argued that there are four stages to the change process:

- *Anticipation* - where rumours abound;
- *Confirmation* - during this period there is information and mis-information and each midwife uses previous experience to reflect on how things will develop;
- *Culmination* - as the information is obtained, midwives will look for clues to help establish meanings. This may include actively seeking information through the available evidence, questioning issues or attending meetings;
- *Aftermath* - occurs once the change has been implemented and tried and tested. The implications of the change are obvious to all, though each individual may view its impact in a different way. Individuals will make predictions and decide whether or not to see the change through or look for alternatives.

In order to manage change successfully midwifery managers must understand theories of change and midwives' response to change, including analysis and understanding of why midwives resist change. In attempting to manage change successfully, managers need to be aware of the existing culture and how to overcome the resistance to change, by promoting an understanding of the organisation, the culture and the change (Hunt, 1997).

Recent changes in midwifery practice (McCourt & Page, 1996) highlight the need to consult and communicate with all midwives involved with the delivery of maternity care, irrespective of whether they will be involved with the study/model of care or not (McCourt & Page, 1996). Any change involving practice brings fear and resentment to those asked to participate either directly or indirectly. The skills and confidence of many midwives have been eroded over the years. Careful planning is necessary to implement any change involving new skills, work patterns and an increase in decision-making skills and judgement (McGinley, Turnbull, Johnstone, Maclellan, 1995). Nonetheless, midwifery managers must have appropriate status within the

maternity care services in order to ensure that midwives can regain their skills and practise the type of care advocated by Changing Childbirth (DOH, 1993) and the Scottish Policy Review (SOHHD, 1993). In Scotland there is a growing concern that midwifery managers have become disempowered and disenfranchised (Hillan et al, 1997) resulting in poorly developed and managed change. Page (1995) argues that as a female profession focused on women's health with a traditionally subordinate position within the maternity services, midwives are not used to taking and using power and being personally and collectively self-determining. The argument is made that people who are used to working in subordinate positions find it easier and more rewarding to stay in that position and sometimes turn in on themselves. It is only if midwives are in a position of power themselves that they can help and empower women. However, midwives do not view themselves or their midwifery managers as having power (Hillan et al, 1997) and consequently may feel helpless to empower women.

Midwives have had to deal with numerous changes in recent years (Barber 1998). In the 1990s Government reports, consumer demands and research evidence all suggested the need for changes in maternity care provision. Midwives probably more than any other health care professionals have been subject to ongoing change. Change in any environment brings fear, anxiety and stress (McGinley, 1993). When this is coupled with increased pressure to improve maternity services, advance education and alter working practices, it can adversely affect job satisfaction and care delivery. In many instances the delivery of midwifery services have been re-organised without any evaluation.

2.6 Summary

The provision of systems of care that centre on the notion of woman centred care are now well underway yet there has been little consideration of the impact of these models of care on the midwife and her practice. In the drive to improve services for women in Scotland, continuity of care was accepted as synonymous with continuity of carer. Concerns about the midwifery workforce and its ability to deliver the models of care came to the fore. Those who participated in the pilot schemes tended to be less experienced junior

midwives (Turnbull, 1995; McCourt & Page, 1996). Due consideration was not given to the underlying philosophy of continuity of care and midwives may have been railroaded into schemes of care which were not appropriate for the area, the midwife, nor indeed the woman herself.

Midwives are motivated and keen to provide optimal care for women (Hillan et al, 1997). But changes in patterns of maternity care combined with decreasing junior doctors hours, setting up out of hours General Practitioner co-operatives and reducing hospital stay for postnatal women may adversely impact on the quality and type of postnatal care offered to women. Improving care by increasing continuity may impact on other elements of service provision and outcome.

The majority of evidence that exists about midwives' satisfaction with new models of care is related to patterns of care which were pilot studies and where midwives volunteered to participate in the study. It is not known whether midwives who volunteer are different from others in terms of personality, drive, motivation and existing job satisfaction. Midwives are concerned that burdens of responsibility will be placed on them that will adversely affect their home life and job satisfaction (Hillan et al, 1997). Little thought was given to the impact of new schemes of care on midwives. The midwife is the key care professional in the postpartum period, but it may be that in striving to achieve targets for care during the antenatal and intrapartum period the postpartum period is neglected.

CHAPTER THREE

ISSUES RELATED TO THE DELIVERY AND OUTCOMES OF POSTNATAL CARE PROVISION

The previous chapters addressed the purpose, potential and organisation of postnatal care and reflected on the midwife's role in the provision of this service. Problems associated with the delivery and evaluation of postnatal care was highlighted and much of the evidence supported the view that postnatal remains a neglected area of maternity services. In spite of the emphasis on woman centred care recent reports continue to highlight concerns about postnatal care. There appears to be little improvement in postnatal care provision and outcome (Audit Commission, 1997).

Midwives are the main professionals involved in the provision of postnatal care, however, it would be an oversimplification to suggest that midwives alone are responsible for the quality of postnatal care received by women. This chapter will address the compounding factors, which influence postnatal care provision and outcomes. In doing so it will address organisational, managerial, psychosocial, and economic issues which affect satisfaction with care and outcome.

3.1 Consumer Views

There may be a difference in perception of need between consumer and maternity care professionals. Determining need amongst the population midwives serve is a complex issue. In the many research projects that examine maternity services some attention is given to consumer satisfaction (Kroll, 1996) yet need and satisfaction do not necessarily equate. Much of the evidence surrounding postnatal care indicates a mis-match between midwives' perceptions of what the women want and the women's expectations (Garcia & Marchant 1996).

The provision of maternity services, and in particular postnatal care, cannot be considered in isolation. Some of the ingredients necessary to influence outcomes centre around organisational structure, patterns of postnatal care, initiatives such as the Baby Friendly Hospital Initiative, the choices and

information offered to consumers combined with their expectations and requirements and finally the transition to, and experiences of, motherhood.

It is only in recent years that professionals have begun to ask women about their views of the maternity services. Indeed, Young (1996) questions why health agencies in countries such as the United States still fail to do so, especially as she asserts that women want to talk about their care and identify to the caregivers and policy makers where the strengths and weaknesses are. Recently, women have been asked their views about models of care which are aimed at providing midwife led care. Not surprisingly, women positively evaluate anything which puts them at the centre of care, increases continuity and reduces the risk of conflicting advice (McCourt & Page, 1996; Shields, Reid, Cheyne, Holmes, Turnbull, Smith, 1997). Consumer views continue to highlight those women who are in minority groups and 'at risk' by virtue of their educational, social or cultural background still feels inadequately supported and cared for (GGHB, 1999; Nolan, 1998; McCourt & Page, 1996; Green, Coupland, Kitzinger, 1988).

Integral to the provision of quality postnatal care is knowledge of what women want from their care and education. In a study to establish what women want to know after childbirth, Moran, Holt & Martin (1997) concluded that postpartum women want self-care and baby care information but stress that this need is not currently met by the current parentcraft educational system. The rationale for this omission may be related to a lack of midwifery perception about the importance of antenatal and postnatal information giving. This finding is further supported by the findings of a recent study to investigate what determines quality in maternity care. This study highlighted that there was a difference in how woman and midwives rated the importance of information giving, ante- and postnatally. It concluded that in order to provide a quality service for women, maternity carers must have a sound knowledge and understanding of the needs of women (Procter & Wright, 1998).

Women identify education as a priority in the postnatal period, but there is a concern that the focus of education is on breastfeeding support and other elements of essential education are omitted. Midwives continue to cite breastfeeding support as a time consuming yet important element of postnatal care. The feeding support that a postnatal woman requires will ultimately play a role in the midwife's decision about whether or not to visit. Marsh & Sargent (1991) established that feeding problems lengthened the postnatal visit by twenty one percent, independent of feeding method. Good practice enhances successful initiation of breastfeeding and in the long term should positively impact on maternal and neonatal well-being and the duration and frequency of postnatal visits.

Conflicting advice has been cited as a major criticism of postnatal care and in particular, hospital postnatal care (Field, 1985). Postnatal women in particular, expressed concerns about initiation and continuation of breastfeeding. A recent National Childbirth Trust study to establish women's experiences of postnatal care (Singh & Newburn, 2000), found that half the respondents (n=480) said that they needed more information and emotional support from health care professionals up to thirty days after the birth. Two thirds of the respondents did not think that there was not enough midwives available to care for them in hospital and twenty percent said that they had only been treated with respect by staff caring for them 'some of the time' or 'never'. In keeping with other studies (Field, 1985), women expressed concern about conflicting advice and the lack of consistent information especially about infant feeding. The women felt that education, information and emotional support from health care professionals was lacking at a time when women are most vulnerable and need it most. Women rated the care they received between days four and ten most positively but felt that there should be support from midwives and other health care professionals from day ten onwards. A limitation of this study is its lack of generalisability, (women self selected to respond, either filled in a questionnaire in an NCT magazine, or Internet web site) the findings are supported by other studies (Moran et al, 1997; Audit Commission, 1997).)

3.2 Women's Health After Childbirth

Many women suffer morbid results of childbirth well after the postnatal period (MacArthur et al, 1991; Glazener, et al, 1993; Garcia & Marchant, 1993). Women's health after childbirth has been a neglected research area and although the problems experienced by many of the women are not major they diminish their quality of life. Glazener et al (1993) suggested a restructuring of postnatal care to allow for the individual needs of women. One fifth of the UK population are estimated by the Child Poverty Action Group to be living in poverty. Those who most need care tend not to seek it and those who need health care least, use it most. Midwives are encouraged to work to counteract the imbalance that exists (Murray, 1998).

Evidence from recent studies has highlighted extensive maternal morbidity following childbirth (MacArthur et al, 1991; Glazener et al, 1993; Garcia & Marchant, 1993). Studies show that postpartum morbidity continues well past the puerperium and can, in many instances, impact on lifestyle (MacArthur et al, 1991; Glazener et al, 1993; Garcia & Marchant, 1993). Bick and MacArthur (1994) found that often women experiencing these problems do not actively seek medical advice and tend to 'put up with' the problem. The legacy of this is an increasing debilitation, impacting on the woman as well as her husband and children. Identification of postnatal morbidity, especially conditions that are likely to continue and become chronic at an earlier stage, would have a beneficial effect on the woman and her family and reduce the subsequent burden on the health service (Louden, 1987; Louden 1992).

As previously stated midwives statutorily provide postnatal care for women up to twenty-eight days postnatally. Yet many midwives stop visiting about day 11(QMH Audit, 1997) even though women are likely to experience or be more aware of problems and complications after this time. Bick & MacArthur (1994) argue for a reorganisation of midwifery postnatal care so that midwives will rationalise postnatal visits and continue visiting beyond the immediate postpartum period. They assert that using midwifery skills to identify and limit the effects of childbirth on maternal health improves the quality of life in

childbearing years and has important implications for women's health and the future use of medical services.

The role of the midwife in the detection, treatment and support of postnatal morbidity is quite clear. Statute (UKCC, 1998) supports the midwives continued attendance on a postnatal woman to twenty-eight days after labour. Local maternity strategies (Greater Glasgow Health Board, 1999; Argyll and Clyde Health Board, 1999) have recognised the importance of early detection of postnatal morbidity and have included in their strategy, provision for the midwife to continue visiting postnatal women for six to eight weeks after the birth of the baby (GGHB, 1999).

3.3 Transition To Motherhood

Rubin, (1967) was probably the first person to give credence to the enormity of change that a woman undergoes on becoming a mother yet nursing and, in particular, midwifery research has only recently begun to consider how this should influence their care. Nursing, and midwifery research has rarely studied the experiences of first time mothers from the vantage point of women themselves (Rogan et al, 1997). The first few postpartum weeks signal a time of immense change for the whole family. It is only by understanding the problems women experience that midwives can ease and facilitate the transition to motherhood. Many women are unhappy, frustrated and anxious following the birth. What is not clear is how midwives (and others) identify and differentiate these women from those who are depressed.

Recent evidence asserts that unhappiness after motherhood is pervasive (Barclay & Lloyd, 1996; Brown, Lumley, Small & Ashbury, 1994). Women may be unaware of the flood of emotions and anxieties they may encounter in the weeks following birth. The perfectly normal distress and concern that new mothers feel is rarely verbalised or reported in the lay press. Maternity care professionals have been slow to identify and discuss these experiences with women. Traditionally the whole focus of care has been on the birth of the baby and the physical health of the mother and baby (Underdown, 1998). The enormity of the impact of parenthood on the father and mother cannot be

underestimated and parents are at increased risk of stress, anxiety and depression. Women argue that they are not prepared for motherhood and that parentcraft education does not always give them the right information. Nolan (1998) questions whether pregnant women are only interested in the outcome of the pregnancy and pay no heed to information about the postnatal period. Other research highlights that there is a statistically significant decline in relationship satisfaction within the first three months postnatally. Women were also found to experience more dissatisfaction with their partner's role than men (Ross, 1999). The community midwife must consider the factors that influence the transition to motherhood combined with the impact of motherhood carefully. The midwife's knowledge of this process will impact on how she cares for the woman and the subsequent support, information and advice that she will give her. The role of the midwife in supporting such an important life transition in the prevention of mental health problems and the promotion of good health postnatally is integral to a positive outcome in the maternity care episode.

3.3.1 Maternal expectations of childbirth and motherhood

Little work has been done to support or refute the notion that if expectations are unmet some form of morbidity will occur (Green, Coupland & Kitzinger, 1990). Work in the United States highlighted that women who anticipated that pregnancy would be enjoyable also thought that caring for their baby would be easy. The study identified gaps in their general education and suggested that additional education was necessary to prepare for future successful parents (Wallach, & Matlin, 1992). In many instances, evidence available is restricted in focus to primigravidae, or particular social classes. Green et al, (1990) established that popular stereotypes were not supported. Those who were less well educated did not want to hand over all control to staff, and women of different levels of education were equally likely to want to avoid drugs during labour. High expectations were not found to be bad for women, although low expectations often were. Feeling in control was associated with positive psychological outcomes. Although this study refuted the common stereotypes it raised questions about women who have low expectations. Green et al, (1990) found that women who had poor expectations were more likely to have

poor psychological outcomes. For midwives, it is important that individual expectations are recognised, as this will facilitate care and should positively affect outcomes. Implicit in this is the expectation that the midwife will understand the importance of identifying expectations and taking the appropriate steps to help achieve these. On the other hand if the midwife feels that the expectations are inappropriate then she may be able to influence or alter expectations so that a positive outcome is more likely.

The postpartum period can be stressful for many parents (Adams, 1994) and women expect their midwife to support them during this time. Women say they are often poorly prepared for parenthood (Hillan, 1991; O'Meara, 1993, Nolan, 1997) but parentcraft teachers argue that the impending labour is the focus of most women's attention (Evans, 1991). Nolan (1998) asserts that postnatal care should start from what the parents, rather than the health carers, have to offer the baby. The components of care required to ease adaptation to parenthood should be based on empowerment and support of patients.

Although heralded as a joyful and exciting time the early weeks of motherhood are fraught with concerns and anxieties. Many women have concerns about baby feeding; fatigue; breast problems; baby behaviour; growth and development; labour and delivery experiences; and other children (Smith, 1989). One way of easing the transition to motherhood is by anticipating and dealing with the concerns and problems before they cause anxiety and stress. Integral to this remedy is a postnatal care pathway which starts in hospital and is followed through into the community.

3.4 Informed Choice/Decision Making By Women

Women tend to be confused by the array of care options discussed in the media and offered in maternity units. Allowing women to have a say in their care helps them to feel in control. Making choices involves three principles;

- The occasion for making a decision;
- Finding the possible courses of action;
- Choosing from the courses of action (Harrison, 1987).

Women wanted to be informed about rationale for decisions and, while they want to be involved in the decision making process, they do not necessarily want to be the one who ultimately makes the decision about a specific element of care (Rennie et al, 1997). However, Hamilton (1998) argues that the circumstances in which women are required to make choices regarding the pattern of care may have some influence on the choice. She goes on to argue that introducing selective visiting during the postnatal period may impede the decision making process by denying the woman the time and opportunity to consider alternatives and making it more likely that she will agree with the suggestions made by the midwife. This can be further compounded by the emotional turmoil experienced by women in the early postpartum period. Hamilton (1998) found that many postnatal women were not aware of the options open to them and were excluded from the decision-making process.

Most women make comments about the 'business of staff' (Marchant, 1997). Procter (1998) highlighted that many women believed that the staff were busy, and did not want to "be a nuisance" or add unnecessarily to the workload. This resulted in women leaving wards or clinics feeling dissatisfied or anxious. Women said that non-verbal communication by staff such as tidying beds and writing notes while waiting for the women to ask or answer was off-putting and did not invite questions and conversation. Procter (1998) found that some women inferred doubts regarding professional competency of staff. There is a view that the responsibility for decision-making is firmly with the woman and that the midwife's role is to inform and advise (Todd, 1998). This may be viewed as midwives abdicating responsibility. What has not been considered in this equation is how the woman feels about having responsibility for all decisions about her care. Nor does this view take into account the emotional and physical state of the woman who is required to make informed decisions in sometimes stressful conditions.

3.5 Women's Perceptions Of Maternity Care And Carers

As early as 1946 nearly 14,000 women in the UK were interviewed to ascertain the costs of pregnancy and childbirth and the extent to which maternity services public and private responded to the needs and desires of

mothers (RCOG, DOH (Scotland), 1946). Audit provides some information about what the women think of their care, but in many instances it is necessary to investigate further in order to establish women's perceptions of maternity services (Garcia, 1997). Evaluating maternity services must consider elements such as choice, options and preferences of women. The majority of evidence surrounding women's perceptions of maternity care suggests that many are unhappy with specific elements of maternity care and in particular hospital postnatal care (McIllwaine, Cole, Twaddle, 1994; Audit Commission, 1997).

While women are sometimes asked generic questions about their perceptions of maternity care (Page et al, 1997; Turnbull, 1996; Murphy-Black, 1992), midwives rarely consider what women think of their carers. Although there is enough evidence available to support the view that midwives can and should offer holistic support and care without adversely influencing the outcome (SOHHD, 1993; DOH, 1993), there is little information about which professional women themselves want to see. General practitioners argue that women want to see them during pregnancy, yet there is little evidence to support or refute this.

In the health service, roles traditionally associated with the doctor have changed. There are now nurse/midwife consultants who have caseloads and nurses and midwives now carry out many procedures like venepuncture, venflon insertion and suturing which were traditionally domains of the doctor. These changes have implications for the assumptions women make about which carer she can expect to provide what area of care (Leach, Dowswell, Hewison, Baslington & Warrilow, 1998). The previous chapter highlighted that although the role and function of the midwife is recognised in statute (UKCC, 1979), there is debate amongst the professions about who should do what. Indeed it seems that even the professionals do not know what their colleagues in the maternity services are capable of (Robinson, 1985).

Recently Leach et al, (1998) investigated women's perceptions of maternity carers and concluded that the majority of women were clear about the role of the midwife in maternity care. Obstetricians were perceived as having a

specialist or emergency role, but many women were uncertain about the specific role of the General Practitioner in maternity care. As all the women surveyed were at least eighteen weeks gestation it may be that their perceptions of the role and function of each professional depended on their prior experience. The argument is made that midwives are more informed about what women want than other maternity care professionals. But a small study in the late 1980s refuted this and argued that there was no evidence that midwives perceived women's needs more accurately than obstetricians (Drew, Salmon & Webb, 1989).

Although midwives perceive themselves as independent practitioners (Hillan et al, 1997) only thirty three percent of General Practitioners and fifty six percent of obstetricians saw them in the same light (Sikorski, Clement & Wilson 1995). The basis for this view is unclear but this professional perception of midwifery skills must surely influence midwifery practice and development.

General Practitioners are keen to be included in any change of midwifery care provision. Failure to do so may adversely impact on the change process (Turnbull et al, 1995). A relationship between mother and General Practitioner can be established during pregnancy and knowledge of her General Practitioner will ensure that if the mother has a problem, she will feel confident to ring him and ask for help postnatally. Antenatal care provides the General Practitioner with baseline information, which will prove useful postnatally. However, this argument is only relevant if the woman sees the same General Practitioner each time and if she continues to do so after the birth.

Many General Practitioner practices adopt specific patterns of care for pregnant women. Some practices have antenatal clinics run by one General Practitioner in particular, while others see pregnant women during the course of their routine clinic. General Practitioners are the most likely maternity care professional to conclude the postnatal care period. They are usually responsible for the six-week postnatal examination, even though the woman

may not have seen her General Practitioner during the puerperium. This policy has recently been called into question (Bick & MacArthur, 1995). In order to successfully deliver high quality maternity care, the organisation and delivery of General Practitioner maternity services should be re-appraised and offered in harmony with other models of maternity care. This should provide a holistic model of care.

3.6 Satisfaction

Measuring satisfaction is multidimensional and may not accurately represent a total response to childbirth (Branadat & Driedger, 1993). Traditionally the notion of satisfaction with maternity care equated with a healthy mother and baby. Branadat et al, (1993) established that fulfilment theory (healthy baby) did not necessarily equate with maternal satisfaction.

Developing and maintaining a high quality service is a key responsibility of the National Health Service and increasingly, quality is becoming a central issue for the National Health Service as a whole (Procter, 1994). A key component of a quality service includes evaluating existing services. Although such evaluations are now commonplace, little is actually known about women's satisfaction with maternity services. Johnston (1995) highlights that consumer perceptions of services have three possible states:

- ***Dissatisfaction*** – when expectations are not met.
- ***Delight*** - when expectations are met or exceeded.
- ***Satisfaction*** – when the service is perceived as adequate (sometimes referred to as 'the zone of tolerance').

Generally speaking women are satisfied with the care they receive "what is - is best" (Porter & McIntyre; 1984; Lothian Health Council, 1992; Cottrell & Grubbs, 1994). However if offered other care alternatives, women may opt for them. High levels of satisfaction with a model of maternity care does not necessarily mean that women would have opted for that if given the choice at the outset (Graham, 1997). Evidence suggests that some women may be reluctant to criticise professional staff while they are still involved in the

system (Tomes & Ng, 1995). Equally, women may be reluctant to criticise and make expert judgement because they themselves lack expert knowledge.

Women complain more about postnatal care than any other element of the maternity service. The reasons for this are complex – it may well be that it is the worst element of maternity care or it could be that they are nearing the end of their care and feel able to talk out and criticise care. Another reason suggested for the criticism of postnatal care is that women are more likely to fault elements of care of which they have some knowledge (Taylor & Cronin, 1994). Finally, postnatal care incorporates a time when many women are in their most emotional and vulnerable state. The transition to motherhood is a complex one and problems encountered by women may be deflected on to the professionals.

The evidence available on satisfaction with maternity services is mainly limited to labour intensive models such as one-to-one midwifery and there is little material available to identify the key components of maternity care which affect satisfaction. Procter & Wright (1998) identified ten dimensions which the women felt were important; each of these will be discussed in turn.

3.6.1 Continuity of carer

Several government reports on maternity care (DOH, 1993; SOHHD, 1993; Audit Commission, 1997) have questioned women's satisfaction with the care they received. Much of the criticism centred around the number of professionals that each woman saw and the levels of conflicting advice received. The Scottish Births survey which was included in the Audit of Maternity Services in Scotland (Penney et al, 1999) highlighted that those women who were seen by more than two people during their care episode were more likely to be dissatisfied with their care. Penney et al (1999) suggested that even though efforts have been made to improve continuity of care throughout Scotland, the impact and success of these schemes have varied. This may in turn impact on levels of satisfaction identified. In the evaluation of the Midwifery Development Unit (MDU) in Glasgow, researchers found that the 'shared care' group of women reported less

satisfaction than with antenatal and hospital based postnatal care. However, levels of satisfaction between the midwifery managed group and the shared care group was similar for intrapartum and home based postnatal care. The reason for this similarity was thought to be because the two models of care were similar in terms of continuity of care during these periods (Shields, Turnbull, Reid, Holmes, McGinley & Smith, 1998).

3.6.2 Environmental/tangible aspects of care

Although midwives agreed that a homely, familiar environment was important to women, especially in labour, women emphasised the reassurance that homelike surroundings conveyed – namely, that their experience was normal (Procter, 1998). Women have expectations about the cleanliness of the hospital and clinics (Procter, 1998). In the Glasgow study, women in the study group rated their satisfaction with hospital postnatal care much higher than shared care women (Shields, et al, 1998). However, women in the study arm had their own homely postnatal ward which was thought to contribute to increased levels of satisfaction.

3.6.3 Information

The importance of adequate information to educate and inform the decision-making process cannot be underestimated (Rennie et al, 1998). It appears that community midwives spend more time giving support and advice. The rationale for this may be because hospital midwives are perceived to be more rushed than community midwives (Kenny, King, Cameron & Shiell, 1993) and women may feel more relaxed about asking the community midwife as she seems to have more time. Providing women with written information is important and the HEBS Pregnancy Book was commended as a measurable criterion for good quality care (Penney et al, 1999). However, although the audit of maternity services established that eighty four percent of women had received the book, no attempt was made to evaluate its role in informing women and enhancing satisfaction.

Information transfer and education impact on maternal satisfaction with care, yet the Scottish Birth Survey (Penney, 1999) highlighted that only fifty one

percent of women had attended any form of antenatal classes and, of these, only twenty eight percent said that the classes had prepared them well for looking after the baby. The nature and quality of information given to the woman throughout her care episode may affect maternal satisfaction (Waldenstrom & Neilson, 1993; Fleissig & Kroll, 1997).

A large proportion of postnatal data focuses on the emotional and psychological support of women. Postpartum women may have a variety of health care concerns, but appropriate information can help reduce anxiety and concern. Moran et al, (1997) highlighted that, although a high proportion of women want self and baby care information, this need is not met as part of the routine antenatal and postpartum education. Even in studies to establish continuity of care, women in both arms of the MDU trial expressed dissatisfaction with information transfer (Shields et al, 1998).

3.6.4 Access

Women value the opportunity of having access to information and maternity care professionals. Procter (1998) suggests that shorter clinic waiting times and locally provided maternity care all positively contribute to satisfaction levels. Access to professional support may also reduce anxiety for new parents.

3.6.5 Care and treatment

Women highlighted explanation of care regimes and procedures as integral to good care (Procter 1998). In a comparison of hospital or home postnatal care the majority of women wanted midwives to listen with interest to what they were saying. Although both models of care compared favourably, notable differences were identified in how rushed the hospital midwives seemed. Over ninety percent of the study group felt that domiciliary midwives had enough time to spend with them compared with only thirty five percent of the hospital group (Kenny et al, 1993). The perception that hospital postnatal wards are understaffed and midwives are rushed and overworked is reflected in many evaluations of postnatal care. The congruence between women's

expectations and the reality of her experience will affect her satisfaction with care (Beaton & Gupton, 1990).

3.6.6 Relationship with carer

Central to maternal satisfaction with care is the relationship the woman has with her caregivers (Oakley, 1993; Brown & Lumley, 1994). Continuity of care and accessibility influence the woman–midwife relationship. A study to investigate the content and timing of postnatal visits established that if the midwife knew the woman well then the pattern and timing of community postnatal care altered (Marsh & Sargent, 1991). Use of a specially dedicated twenty-four hour telephone line may provide support for women. The midwife-woman relationship based on mutual trust and confidence is considered to provide psychological as well as physical support to the woman. Kaufman (1998) describes ways in which midwives can strengthen this partnership by information giving, support and care which will ultimately improve satisfaction. In the context of postnatal care, midwives are encouraged to get to know the woman before the birth of the baby so that the relationship is present and can be built upon. Positive relationships facilitate conditions which influence satisfaction with care. These relationships are best fostered through a woman centred service where women can exercise informed choice and have some control over the process of care (Tinkler & Quinney, 1998).

3.6.7 Outcome

All midwives and parents identify the successful birth of a live healthy baby as being the key outcome measure (Procter, 1998). Once this outcome is achieved the woman and her partner may have other priorities which can then be addressed following the birth of the baby. Negative outcomes, such as lack of control or unsupportive care, which may lead to disappointments such as giving up breastfeeding, may adversely influence satisfaction levels.

3.6.8 Attributes of staff - personal and professional

Women need to know that they are being cared for by competent, professional yet caring staff (Rennie et al, 1998; Procter, 1998). In the context of postnatal

care women need to feel confident that the midwife has the knowledge and experience to care and support mother and baby adequately.

3.6.9 Choices

In offering consumer choice, women must be given adequate information about the alternatives available to them, as well as the opportunity to implement their choice (Rennie et al, 1998). Studies highlight that different women want different things (Shields et al, 1998).

3.6.10 Control

In order to improve outcomes and quality of care women must be informed of choices available to them and feel that they have some control over the whole care process (Tinkler & Quinney, 1998). Measurement of maternal satisfaction is complex (Bramadat & Driedger, 1993). In determining women's satisfaction with postnatal care it is worthwhile reflecting on the differences in perceptions between women and midwives (Procter 1998). The dimensions of care are interrelated. Instead of being taken individually they are best considered as a whole.

3.7 Methods Of Measuring Satisfaction

Many factors influence measurement of satisfaction with maternity care. However, central to accurate assessment is consideration of women's expectations and preferences related to childbirth and the puerperium (Bramadat & Dreidger, 1993). The impact that satisfaction has on long-term outcomes, adaptation to parenthood, relationship with infants and others, and expectations with future births are still being evaluated. Identifying a multifaceted tool to measure all aspects of maternal satisfaction is complex. Traditionally methods of measuring satisfaction have been simple, sometimes relying on women using one rating scale or using scales such as willingness to pay (Donaldson, Hundley & Mapp, 1998). Branadat et al (1993) asserts that although women may score highly on satisfaction with childbirth and maternity care, unsolicited comments include many negative views. Forced choice and Likert style statements elicit fewer negative responses than open-ended questions.

The timing of the satisfaction measurement also impinges on the outcome. Evidence suggests that significant changes in satisfaction are unlikely to occur during the early postpartum period (Hodnett, 1987; Bramadat & Dreidger, 1993). But satisfaction measurements over a longer period highlight more complex issues (Bennett, 1985; Simkin, 1991; Simkin, 1992).

Many factors can influence a woman's satisfaction with childbirth; although she may be satisfied with her care she may not be totally happy with it. Satisfaction is only one of a complex series of psychological responses to childbirth (Green et al, 1988; Green et al, 1990). Indeed, satisfaction waxes and wanes during the maternity care experience.

Although debate exists about the place of hospital postnatal care, some women may wish to stay in hospital for a few days after birth. Early discharge programmes of postnatal care are considered appropriate provided they are the choice of the woman (Kenny et al, 1993). Women want an active say in their care and this positively affects satisfaction with care (Brown & Lumley, 1998; Brown et al, 1994; Jacoby, 1987). If women have not been involved in their care choices they are more likely to be dissatisfied (Waldenstrom, 1989).

3.8 Summary

This chapter addressed issues, which are central to the delivery and outcome of postnatal care. In order to function adequately as a mother the transition to motherhood should be as seamless as possible. Integral to this is the provision of education, support and backup for each new mother. Good health is an important component of motherhood and midwives can facilitate this in numerous ways.

Maternal expectations of childbirth and motherhood are rarely mentioned in the obstetric and midwifery literature yet the impact of motherhood has extraordinary effects on maternal well-being (Barclay & Lloyd, 1996; Rogan et al, 1997). Few women are aware of the effects the transition to motherhood will have on them. New mothers express surprise at the physical and

emotional turmoil they experience (Smith, 1989). High levels of maternal morbidity are a concern (Glazier et al, 1993; Bick & MacArthur, 1995; McVeigh, 1997) to all health care professionals especially midwives. Although preventative medicine is the best policy, organisational change of maternity services together with pregnant women's apparent apathy and indifference with postnatal care, make this difficult to achieve.

In any health care setting it is difficult to measure satisfaction with care and a maternity care setting makes this even more complex (Procter, 1998). The notion that satisfaction is associated with a 'healthy mother and baby' is no longer enough. Only recently has the importance of psychosocial outcomes been considered. Women express more dissatisfaction with postnatal care than any other element (Audit Commission, 1997; McIlwaine et al, 1994; Field, 1985) but the rationale for this is blurred. It may be that women wait until after the event to complain and then they complain about things of which they feel they have some insight and knowledge (Procter, 1998). In this environment it can be difficult to measure satisfaction with care given, as there are so many compounding factors which influence the outcome. Women still identify with their own experience as the better options of care available that is 'what is, must be best' (Porter & McIntyre, 1984). Women's knowledge of the care they will receive together with their expectations can influence satisfaction. If expectations of care are not met then dissatisfaction is more likely (Waldenstrom, 1989).

CHAPTER FOUR

AIMS AND METHODOLOGY

Aims and Objectives

The aim of the study was to examine postnatal care provision before and after the introduction of a new model of postnatal care within a University Teaching Hospital in the West of Scotland. The specific objectives were to:

1 Investigate women's perceptions and experiences of postnatal care;
2 Examine the current pattern of postnatal care provision in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction;
3 Evaluate the new model in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction;
4 Compare the outcomes of both models;
5 Evaluate midwives' perceptions of both models of care.

4.1 Setting For The Study

The setting for the study is a large University Teaching Hospital in the West of Glasgow that delivers 3,600 women per year. The catchment area is mainly urban with a mix of socio-economic groups. Although Scotland has only a very small population of minority cultures, the majority live in the west of Glasgow within this hospital's catchment area. In order to establish the background and baseline information for the study an audit of existing postnatal practices was completed in 1997. The researcher reviewed the records of all women discharged from the hospital during November 1996 (n=347). The audit demonstrated that ninety-eight (28.2%) women, who delivered in the hospital, lived outside the hospital catchment area for community based postnatal care. Of the 249 women who lived within the catchment area, 46.2 % (n=115) were primigravidae and 53.8% (n=134) were multigravidae.

The mean length of postnatal stay was 3.7 days (SD 1.6, range 1-6), although there was a statistically significant difference for this variable between primigravidae and multigravidae (4.26 v 3.16 days, t=-5.7, p <0.0005). The length of postnatal stay was significantly longer for those who had an instrumental delivery (4.08 days v 3.23 days, t = -3.16, p <0.002), Caesarean section (5.03 days v 3.23 days, t = -6.330, p <0.0005) and for those who were breast feeding (4.0 days v 3.42 days, t = -2.734, p <0.007). The mean number of postnatal visits to women after discharge by the community midwives was 4.69 (st.d 1.45, range 3–9). It was not possible to determine from the case records and midwifery notes the actual number of midwives who visited each woman.

In an effort to ensure that care was based on individual need and to enhance continuity of care, staff in the hospital wished to develop and evaluate a new model of care which aimed to provide a woman centred approach to postnatal care provision in the west of Glasgow. The new model would tailor care to the individual needs of women and their babies rather than on a blanket policy or regime. As far as possible a woman would meet her midwife prior to discharge home and the same midwife would carry out all the visits for each woman, ensuring continuity of care and reducing the risk of conflicting advice and confusion.

4.2 Background To The Methodology Of The Study

As explained in the introduction the majority of this study was funded by the CSO Research Training Fellowship, consequently it had to meet identified criteria and be completed within a specific timescale. A combination of research methods and tools were used. Attention was paid to the aims and outcomes of each aspect of the study in order to ensure the appropriateness of the research method and tools used. The decision to use postal questionnaires for the main part of the study was supported by evidence that response rates of seventy five percent can be expected from maternity care related questionnaires (Mason, 1989), although there was some concern that new mothers may have more pressing priorities than completing questionnaires.

Cartwright's (1988) work gave credence to the use of questionnaires to establish satisfaction with the care they received

The main focus of this study was to develop and evaluate a new template of community postnatal care using a before and after study. In order to inform this template a smaller yet complementary study took place to establish primigravid women's expectations, perceptions and experiences of postnatal care. This information was obtained using a series of antenatal and postnatal focus groups with primigravid women. The focus groups took place over a six-month period in 1997 and were facilitated by the author. All elements of the study took place in the west of Glasgow. The study was divided into three Phases with specific objectives for each Phase.

4.3 Sampling And Population

Two hundred and fifty women (250) women will be included in **each** phase of the study (n=500). Statistical advice was sought from a medical statistician. The proposed sample size will allow for detection of differences in satisfaction rates of women but will only rule out large differences in clinical outcomes.

Estimation of satisfaction - Using 250 women in each group gives 80% power to detect, at the 5% level, a difference of 0.25 units between the mean satisfaction scores of the two groups, assuming a within group standard deviation of 0.75 units.

Estimation of Clinical Outcomes - In a study of this size it is only possible to rule out large differences in clinical outcomes. A study with this sample size would allow detection, with 80% power at 5% significance level, of a difference of the order of 10% in one group versus 20% in the other group.

Clear criteria for entry into the study were identified:

- women who live in the west of Glasgow
- women who have had a normal delivery
- low risk mother and baby
- healthy baby at term
- no postnatal complications to mother or baby
- mother and baby discharged home together
- women who have given informed consent

- women who have access to a functioning telephone.

Women who meet these criteria will be identified in the low dependency postnatal ward and informed of the study both verbally and in writing by the midwife. A copy of the signed consent form will be placed in the case notes. Women who do not wish to take part in the study will be excluded In order to evaluate the current and new patterns of postnatal care provision in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction, a consecutive sample of low risk women who meet the criteria for entry into the study will be approached by a postnatal ward midwife prior to discharge from hospital and asked to participate.

4.3.1 Organisation of the Study

The study comprises of four main elements:

- Focus group work to investigate women's expectations, perceptions and experiences of postnatal care (April and August 1997).
- Evaluation of the existing model of community postnatal care (1997).
- The introduction of a new template of community postnatal care (1997-1998).
- Evaluation of the new model of community postnatal care (1998).

In order to simplify the presentation of findings, the work has been divided into three phases.

4.4 Phase 1: Examination Of Current Postnatal Care Provision

This phase of the study was used to yield baseline information about existing patterns of, and attitudes to community postnatal care in the west of Glasgow. Objectives one, two and part of five were achieved during this phase of the study.

4.4.1 Objective one

Objective one 'To investigate women's perceptions and experiences of postnatal care'. In order to obtain this information, focus groups were used.

4.5 The Concept Of A Focus Group

A focus group is a group interview or discussion on a specific topic or involving people who have similar characteristics. This technique is used to determine feelings and opinions of small groups of people (Dilorio Hockenberry-Eaton, Maibach & Rivero, 1994). Focus groups vary in size (two to twelve), may meet one or more times, may have a formal or informal agenda and can be part of a multi-method study (Ward, Bertrand, Brown, 1991). The planning and execution of focus groups is problematic.

> *"Focus groups are useful when it comes to investigating what participants think, but they excel at uncovering why participants think as they do."* (Barbour, 1995)

Focus groups combine qualitative research methods and theories of group processes in order to provide original data. Attention to details including group membership is essential in order to achieve the stated objectives. Possible variables must be taken into consideration; using homogenous groups may minimise this. Most focus groups have a moderator to ensure that the objectives of the research are achieved (Reisken, 1992; Frey & Fontana, 1991; Greenbaum, 1988; Hughes & Dumont, 1993; Ward et al, 1991). The task of the moderator is to facilitate discussion, not to interview. A sound understanding of group dynamics is paramount.

Encouraging participants to interact with each other ensures a richness of information and the moderator must capitalise on the communication between participants in order to generate data (Kitzinger 1995). Focus group participants are encouraged to talk to each other, ask questions and exchange anecdotes and comment on each other's points and views (Kitzinger 1994). Focus groups have many strengths; many limitations also exist. As with any research project problems must be teased out in order to prepare the focus group schedule. Validity of responses was ensured by the researcher repeating answers and key points to the group to ensure and confirm that the correct interpretation had been reached.

Focus groups are regarded as cost effective, relatively easy to conduct and a quick way of obtaining rich information on a given topic yet many organisers

of focus groups find then difficult to plan, organise and the resulting data time consuming to analyse. Focus groups may be on a particular topic of interest or the group may be focused in the sense that the participants have common characteristics (Dowell, Huby, Smith, 1995). In the case of the postnatal care study the participants were all interested in the topic of postnatal care and were focused as a group in that they were all pregnant for the first time.

The early 1960s saw marketing and advertising professionals using group interviews (Dilorio et al, 1994) and the nineties has seen an increasing trend to use focus groups in health service research (Nymathi & Schuler 1990; Garbett, 1994; Macintosh, 1993). Increasingly management in all walks of life are turning to the use of focus groups to aid their decision making process (Macleod-Clarke, Maben & Jones 1996; Dowell et al, 1995). Yet focus groups cannot be seen as a panacea for identifying consumer views (Neil, 1997).

As the information obtained in this element of the study centred on women's perceptions, expectations and experiences a qualitative methodology was considered the most appropriate. Following an extensive review of the literature focus group methodology was identified as the most appropriate method of obtaining the answers to the research questions.

Criticism has been levelled at those who resort to focus groups in order to inform policy and decision making process (Neil 1997). Indeed it may be argued that not only are they used unwisely but also insufficient attention is paid to analysis (Carey & Smith 1994). Focus group methodology is relatively new to midwifery research. Time and energy must be spent identifying its strengths and limitations in maternity care settings. Although the literature regarding focus groups is expanding there are still many grey areas and much has still to be learned about this research tool.

4.5.1 Focus group methodology

Quantitative methodology was considered inappropriate as the study particularly wanted to centre on women's expectations, fears and experiences

of postnatal care and the use of questionnaires would loose some of the richness which could potentially be obtained from using a qualitative methodology. Personal interviews were the original method of choice, however on reflection and discussion with other researchers it was considered that the use of a focus group methodology would provide a wealth and variety of information not readily available from individual interviews. Interest in exploring whether consumers are satisfied with their care is increasing (Handler, Raube, Kelley & Giachello, 1996), yet little is known about women's expectations of the care they will receive. A recent study in Grampian highlighted that many women's expectations of what they want and will need in labour are different from what they actually want in labour (Rennie et al, 1998). The focus group approach is suited to understanding individual perceptions of well-being and care.

4.5.2 Facilitating focus group discussions

The role of facilitator is a complex one, as focus groups can be structured, semi-structured or unstructured. Essentially the facilitator ensures that there is sufficient interaction, that key topics are debated, takes appropriate field notes and ensures that the objectives of the research are achieved. (Greenbaum 1988, Reisken 1992, Frey & Fontana 1991). In this study the facilitator was the researcher. The facilitator identified herself as a researcher interested in postnatal care who was also a midwife and mother. Debate exists over using a health care professional as a facilitator as patient groups may experience conflict and find the presence of a health professional intimidating. In this instance the participants understood that whilst the researcher was a midwife she was not an employee of the Trust. However the possible bias introduced by the sample knowing that the facilitator was a midwife must be taken into account.

4.5.3 Analysis of focus group data

Focus group material tends to be analysed using qualitative research techniques. The overall goal of analysis is to structure the focus group data for clear communication to others (Dilorio et al, 1994). Using the research questions the focus group data as well as field notes are classified into themes.

Methods of analysis focus group material are not well developed (Carey & Smith, 1994). Qualitative data analysis requires lateral rather than linear thinking (Morse, 1991). Coding is analysis and as Myles and Huberman (1994) state

> *" to review a set of field notes, transcribed or synthesised and to dissect them meaningfully while keeping the relations between the parts intact, is the stuff of analysis". Data is differentiated, combined and reflected on. The goal of analysis is to structure interview data for clear communication to others "*
>
> (Dilorio et al, 1994)

4.5.4 Focus group discussion outline

Focus groups are usually guided by open-ended discussion guidelines (Reisken, 1992; Kreuger, 1994; Polit & Hungler, 1995). An outline topic, guide based on the research objectives, discussion with peers and other researchers, and available literature, was devised and broadly covered the areas identified below (topic outline Appendix V and V11).

- The forms of support women anticipated and then experienced postnatally;
- Identification of women's perceptions, expectations and experiences of postnatal care;
- Women's perceptions and experiences of the role of the midwife postnatally;
- Women's descriptions and experiences of motherhood.

4.5.5 Sample for focus group study

Selection of a sample, which is representative of the full population, would have been difficult to organise logistically as well as organisationally, so a convenience sample was used. Women under the care of The Queen Mother's Hospital attend a variety of clinic sites for antenatal care as well as parentcraft. As some antenatal clinics were held at health centres sampling could have been possible by geographical area but not by occupation or marital status. As case notes no longer contain information about occupation or marital status, the only way of identifying social class was by postcode. For ease of access and to avoid the women having to make extra trips to the clinic and incur travelling expenses it was decided to select the sample from women who were attending parentcraft classes run by either community midwives or parentcraft

staff. Using this group of women excluded those who did not attend parentcraft classes.

It is acknowledged that this sample may not be representative of the whole antenatal population at The Queen Mother's Hospital (QMH) as approximately only fifty two percent of women attend preparation for parenthood courses (Penney et al, 1999). An added dimension is that may women who deliver in the QMH are outside the community midwives' catchment area and therefore will not be visited by QMH midwives. The research midwife attended a series of preparation for parenthood courses during a two-week period in March 1997, the study was explained to the women and women were given the opportunity to volunteer to participate in the focus groups. Women were given a written description of the study and a consent form, which they were asked to take home and consider (Appendix I, III and IV). If they decided to participate in the study they signed the consent form and met at the previously agreed time and venue.

All focus group sessions took place in the teaching room sited beside the antenatal clinic, were audio-recorded and lasted about 40 minutes. Following a pilot study, the main study took place in April and August 1997. Between three and five women attended Focus Group One and between two and four attended Focus Group Two. The date time and venue for the second focus group was agreed at the end of the first focus group session. In spite of recent policy to provide incentives for consumers to participate in research no incentives were offered to the participants of the focus groups. No attempt was made to match backgrounds in terms of age, marital status and parity.

The research midwife facilitated all six focus groups. A crucial role of the facilitator is to take field notes, which help with the interpretation and analysis of the recorded discussions. A sample of primigravid women participated in focus groups at approximately thirty-four weeks gestation to establish their perceptions, knowledge and expectations of postnatal care and again six to eight weeks postnatally to establish their level of satisfaction with the care they received and whether their expectations were met.

4.5.6 *Coding of focus group data*

Coding of data was carried out manually with the help of Microsoft Word to cut and paste data. Although much has been written about the use of computer packages to help code qualitative data, (Myles & Huberman, 1994; Mason, 1996), the complicated aspects of analysis for this study meant that, although time consuming, initially using cut and paste facilities in Microsoft Word, simplified matters in the long run. The researcher considered the software options available but felt that as an educational and research process it was more helpful to code and analyse the data manually.

All categories were indexed cross-sectionally, i.e. the same lens was used to explore patterns and themes which occurred across the data (Mason, 1996). Categories were identified which reflected the study aims and objectives. However, as analysis developed, other categories were identified. The coding process took place in a manner similar to that described by (Myles & Huberman, 1994). New themes and codes developed as the study progressed. In a couple of instances, the issues identified did not fit neatly into any of the identified categories and these were put into a general category. In some instances issues crossed categories. Following initial identification of the descriptive categories considerable work took place to highlight the conceptual categories in the data.

4.5.7 *Stages of analysis*

The stages of analysis, although separate entities, culminated in a single piece of work. The analysis of this material was further complicated by the fact that this was a before and after study.

4.5.8 *The common themes*

The tapes were played frequently in order for the researcher to familiarise herself with the data. Following initial analysis of the before and after focus groups, the data were categorised manually with the help of the cut and paste facility in Microsoft Word. Although time consuming and cumbersome, organising the data manually familiarised the researcher even more with the

material. The themes were separate entities; some of the themes overlapped and in certain instances issues are re-iterated to reinforce certain themes.

Analysis of the transcripts took four formats.

1 Each individual focus group was analysed for content and the transcript proof read and cross-referenced with the tape recording of the session. Field notes were used to support the information obtained from the transcript. Attention was paid to group dynamics and involvement of each group member in the discussion. Although social class and education were not identified as factors necessary to the homogeneity of the group, it did transpire that this did influence the outcomes of the focus groups. The group members knew each other as they had attended parentcraft classes together for the six weeks before the focus group was conducted. Thus, the group processes were already in play and as the focus group progressed, it was possible in some instances to identify individuals to whom the other members deferred.

2 The analysis of the antenatal focus groups was completed and descriptive categories were identified. A detailed summary of the findings was prepared.

3 Analysis of the postnatal groups took place in a similar manner to the antenatal groups although groups differed slightly in composition as fewer women attended the postnatal groups. As there were fewer women in two of these groups this would have altered the group dynamics from that of the antenatal discussion.

4 The final category for analysis was a comparison of ante and postnatal responses for each group. This involved considerable analysis and deliberation as, in many instances, there was a real shift in women's attitudes and views from the antenatal to the postnatal period. This forms the most substantial component of the analysis.

4.6 Objective Two

Objective two to examine the current pattern of postnatal care provision in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction

was achieved by means of a postal questionnaire and retrospective review of notes (a copy of the questionnaire is included in appendix XV).

Data on clinical outcomes was gathered through a retrospective review of records (shared care card, maternity case record, midwifery kardex and woman-held notes) and from information obtained from the postal questionnaire. Information included demographic details, information about the pregnancy, labour and delivery, postnatal care of mother and baby including the method of feeding, number of community midwife visits, number of wasted visits, outcomes of the visits and postnatal complications.

A consecutive sample of low-risk women (n=208) from the low dependency postnatal was recruited to the study. Women who met these criteria were identified and informed of the study both verbally and in writing by a midwife in the postnatal ward (Appendix XI). A copy of the signed consent form was placed in the case notes (Appendix XII).

The specific objectives of the maternal questionnaire were to:

- Assess maternal satisfaction with the pattern of postnatal care;
- Examine women's views of the amount, content and outcomes of the postnatal visit;
- Consider women's perceptions of the postnatal support they received.
- Identify clinical outcomes

The questionnaire was based on previously validated tools but incorporated a number of new questions in order to meet the objectives of the study (Astbury et al, 1994; Brown et al, 1994; Cox et al, 1987; Tucker, Hall, Howie, McMillan, 1996; Likert, 1932; Mason, 1989, Stone, 1993). The development of the questionnaire went though a series of stages. A literature review and a focusing on the research questions provided background material. Discussions with midwives, supervisors and researchers proved extremely helpful, resulting in a clear, succinct and easy to complete tool, which would allow the research questions to be answered. As the questionnaire was being posted to new mothers, it was essential that nothing in the questionnaire would be likely to provoke anxiety or concern. For this reason the final copy of the

questionnaire and proposal was reviewed and approved by a Consultant Psychiatrist who has a specialist interest in the postpartum period. The questionnaires were sent with a covering letter (Appendix XIII) and stamped addressed envelope to the women three weeks after delivery. A reminder letter and second questionnaire was sent to non-respondents approximately three weeks following the initial mailing (Appendix XIV).

4.6.1 Pilot study

A pilot study took place in April 1997 and achieved a sixty five percent response rate. The aim of the pilot study was to determine the:

- Clarity of the questions;
- Effectiveness of the instructions;
- Completeness of response sets;
- Time required to complete the questionnaire;
- Success of the data collection technique (Burns and Grove, 1993).

Only minor amendments were required to the questionnaire. The main study took place between May and September 1997.

4.7 Objective Five

Objective Five to evaluate midwives' views of current postnatal care provision was achieved by distributing anonymous questionnaires all midwives working within the integrated community team at the hospital (n=20). The specific objectives of the questionnaire were to:

- Evaluate midwives' views of current postnatal care provision;
- Assess midwives' satisfaction with the patterns of postnatal care they provide;
- Identify factors which influence midwifery decision making with regard to planning of postnatal visits and care for individual women.

The questionnaire developed for use by community midwives went through a similar developmental process to the maternal questionnaire. An extensive literature review, attention to other relevant tools, in particular the questionnaire previously used to assess midwives perceptions of woman

centred care (Hillan et al, 1997) and piloting, produced the present version of the questionnaire. Since the sample size for this part of the study was small, a decision was made to make the questionnaires anonymous in the hope that this might lead to franker responses, a letter accompanying the questionnaire explained this (Appendix VIII). Follow-up of non-respondents was therefore not possible. A copy of the questionnaire is included in Appendix 1X.

4.8 Phase 2: Development And Implementation Of The Woman Centred Template Of Postnatal Care

The new model of care incorporated the findings of the initial audit and the information obtained from the focus groups. Following assimilation and evaluation of this information midwives met and discussed possible options for postnatal care delivery. Midwives who worked in the community and low dependency postnatal ward as well as midwifery managers were involved in the development of the new template for postnatal visiting. Once the midwives were satisfied with the template an implementation plan was developed. In keeping with other studies (Garcia et al, 1994) this study highlighted that once the protocol was introduced, its acceptance and implementation by the midwife was less clear. Unease about selective postnatal visiting is evident in the literature (Hamilton, 1998); yet, the midwives did not voice this concern. The development of the template was an evolutionary process which considered all the available evidence and midwifery opinion. Once the template was finalised obstetricians were informed of the proposal.

The new pattern of community postnatal visiting was introduced in October 1997. The new template of postnatal care involved discharge of low-risk women from hospital within forty-eight hours of delivery. Given the national trend to reduce hospital stay, wherever possible, and lack of evidence in support of longer hospital stay, it was considered appropriate for midwives to offer discharge from hospital to well women and babies forty-eight hours following delivery. The postnatal visiting policy was to be based on individual need (maternal or neonatal), although each woman would have a minimum of three visits from the community midwives after discharge. The first visit was to take place within twenty-four hours of discharge; the second

on day seven to complete the Guthrie test and a final discharge visit was scheduled for around the tenth postnatal day before discharging the woman to the care of the health visitor.

Women were advised that they could telephone the hospital at any time for support and advice if they experienced any problems. It was anticipated that the woman would have twenty-four hour access by telephone to a community midwife (although not necessarily the midwife who was visiting her), but as The Queen Mother's Hospital community midwives only did 'on call' for women expecting a DOMINO confinement this was not considered appropriate. Women were given the phone number of the community midwives who they could contact during 'office' hours, and were told that they should telephone the postnatal ward any time outside these hours.

Recent statistics have suggested that ninety one percent of households in Scotland now have a telephone and the provision of a phone number for clients' use has been extensively evaluated (Peterkin, 1995). Discharging low risk women early and reducing the number of required visits to three, reduces the risk of conflicting advice and ensures continuity of care and carer in the postnatal period.

All community midwives involved in the study agreed that three visits was the minimum number of visits that could be introduced without compromising maternal and neonatal outcome and satisfaction. Midwives were asked to justify each visit and be explicit about the rationale for any extra visits. Any postnatal visits by the midwife outwith the defined schedule were to be based on identified maternal and/or neonatal need. In order to manage the change successfully, a series of staff workshops were organised from within the hospital. The research midwife had no input into this process.

4.9 Phase 3: Evaluation Of The New Model Of Postnatal Care

The new model of care was allowed to run for four months before the final part of the study was conducted. This was to allow time for the new model to

become embedded in practice. Phase 3 was conducted from February - July 1998.

Objective Three: *To evaluate the new model of care in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction.*

In order to achieve Objective three, the methodology developed for Phase 1 – Objective two was again utilised. A further consecutive sample of 205 women was recruited from the low dependency postnatal ward.

Data on clinical outcomes was gathered through a retrospective review of records and the self completion questionnaire, and maternal satisfaction was assessed by means of the questionnaire sent three weeks after delivery. The same instruments from Phase 1 were used for this part of the study.

Objective Five: *In order to achieve objective five, questionnaires were distributed to all midwives working within the integrated community team at the hospital (n=20) during May 1998.*

On this occasion, the questionnaire was amended to include specific questions relating to the new template of postnatal care (Appendix X).

4.10 Data Analysis Of Questionnaires

The research midwife coded data from the questionnaires and completed the retrospective review of case notes. This was entered into a computer using the Statistical Package for the Social Sciences (SPSS for Windows). This package acts as a database and allows any necessary recoding, transformation and exclusion of cases during data analysis. For quantitative data, basic descriptive statistics were calculated for all of the variables and bar charts or histograms requested, to ensure that the data was approximately normally distributed. When continuous variables were compared between the two groups (e.g. age, number of postnatal visits), the unpaired (two sample) t-test was applied. When continuous variables were compared a 95% confidence interval for difference between the two groups was calculated.

For categorical variables, the Chi-squared (X^2) test for independent samples was used in the analysis. The conventional criterion for the test to be valid is

that at least eighty percent of the expected frequencies exceed five and that all the expected frequencies exceed one. If this condition were not met, then categories within the tables were combined to raise the expected values before the test statistic was applied. It is argued that the X^2 test should be modified for 2x2 tables. If any table has an expected value of less than five, or a total sample size of twenty or less, SPSS automatically proceeds with a 'Fisher's Exact test' (Fisher's test is also valid for larger samples). This test is an alternative to the X^2 test with continuity correction and was applied to all 2x2 tables. The Fishers Exact test determines the exact probability of obtaining the observed result or one more extreme, if the two variables are independent and the marginal totals are fixed (Puri, 1996).

The Mann-Whitney U test was used to examine the difference between midwives' answers to the Likert style questions. The Mann-Whitney U test is a non-parametric test and has the advantage that the only assumption required about the distribution of the data is that the observations must be ranked, as is the case with Likert responses (Bland, 1987). This is an unusual, but appropriate application of the Mann Whitney U test, as the categories are ordered the Mann Whitney U test can be used as a replacement for the X^2 Test. Throughout the text p values of less than 0.05 are taken as statistically significant. As the midwives questionnaires were anonymous (pairs could not be matched) it was not possible to use the Wilcoxon matched pairs test to examine the difference between midwives responses to the Likert style questions.

Following analysis of the data the outcomes of both models of postnatal care were evaluated and discussed. Recommendations based on the findings of the study will be presented in the final chapter.

4.11 Ethical Approval

Ethical approval for the study was sought and granted from the Ethics Committee of Yorkhill Hospitals, NHS Trust. The committee requested copies of the research proposal and all written material comprising information sheet, consent form, accompanying letters and questionnaires that

each woman would receive (see attached appendices). The committee paid particular attention to the content and timing of the postnatal questionnaire. It asked that a psychiatrist with a special knowledge of the postpartum period review the questionnaire and that the Edinburgh Postnatal Depression Scale be omitted from the questionnaire. A psychiatrist who specialises in puerperal disorders reviewed the questionnaire and agreed that it would not cause any undue stress to a postnatal woman. The ethics committee requested, that if required, only one follow up letter be sent to each woman. Permission was obtained to review case notes and the birth register to obtain the relevant medical and obstetric information. All focus group tape recordings and field notes were destroyed at the end of the study. Confidentiality of the women in the study was maintained at all times. Ethical approval for the study was granted in April 1997.

4.12 Limitations Of The Study

The choice of study design may be seen as a limitation. This is because a randomised controlled trial would have been more rigorous than a before and after trial. However, the chosen method allowed the change to be evaluated without disruption to normal maternity services. This before and after study was conducted within the specific time frame and restricted resources of the CSO Research Training Fellowship. It was a pragmatic study which utilised the available resources and aimed at maximising the quality of care and choices available to women. The benefits of using a before and after study in similar circumstances were highlighted by Twaddle et al (1993).

The quality of the information detailed in the woman-held notes proved to be a limitation of the study, as the review of case records and woman-held notes was dependent on the accuracy and completeness of information recorded in them by the midwife. The midwife was the only health care professional to record information in the woman-held notes. Although midwives had been asked to record specific details of the postnatal visit, midwives tended not to record the duration of visits, rationale for and content of visits. Omissions in the demographic data included that occupation and partner status were not

recorded in maternal case notes. Recruitment of women to both aspects of the study took double the anticipated time. It is unclear why this was the case.

A case study approach to evaluating midwives' perceptions of both models of care may have yielded added insight into the way in which community midwives make decisions about care and the way in which they work and support each other.

The focus group approach was considered an effective, efficient and appropriate methodology to establish women's perceptions and experiences of community postnatal care. Comparison of focus group and interview methodology suggests that certain concepts were more likely to occur in focus groups than individual interviews, however, no difference was noted in the depth of data generated (Thomas, Macmillian, McColl, Hale & Bond, 1995). Limitations of this approach may be related to the size of the groups, (especially in the postnatal period), the number of groups which took place, and the population from which the women were derived. These limitations were overcome by the fact that although the women in the groups were not homogeneous in terms of background, they were homogeneous in that all were primigravidae and of approximately thirty-six week gestation. All three groups of women were cohesive with excellent group dynamics. All identified similar issues which they debated. Thus saturation of topics and data was reached early in the study reducing the need to use further groups of women.

A further limitation of the focus group study may have been that the facilitator was a midwife. This may have introduced a bias and influenced the discussion which took place.

As with any study of this nature more resources and time might have altered the research approach and methodology. However, in spite of the limitations, the study provided a wealth of information on midwifery care in the postnatal period.

SECTION TWO

CHAPTER FIVE

WOMEN'S EXPECTATIONS, PERCEPTIONS AND EXPERIENCES OF COMMUNITY POSTNATAL CARE

The aim of this element of the study was to establish women's perceptions and experiences of community postnatal care with a view to developing a new template of community postnatal care provision. Criticism has been levelled at the maternity services for not involving patients/consumers in the planning phases of change. Gready, Buggins, Newburn, Draper, Fletcher, Dodds & Wang (1997) argue that patients/consumers are less likely to be constrained by logistics and more likely to highlight ideal situations. Feedback from consumers enables midwives to reflect on practice and modify their care accordingly. Interest in exploring whether consumers are satisfied with their care is increasing, (Handler et al, 1996) yet we know little about women's expectations of the care they will receive. This element of the study provided useful information about the women's perceptions and experiences of postnatal care.

5.1 Aims And Objectives Of The Study

The aims and objectives of the study:

- To identify women's expectations of their needs, care and support during the postnatal period.
- To examine women's perceptions and experiences of the care they actually received during the postnatal period.

In order to answer the research questions, groups of women participated in the focus groups, antenatally at 36 weeks gestation and again six weeks following the birth of the baby. An outline topic guide based on the research objectives; discussion with peers and other researchers and available literature was devised (Rescan, 1992; Krueger, 1994; Polit & Hunger, 1995) (see appendix V and V11). The previous chapter highlighted the development, organisation, management and analysis of the focus groups. This chapter will present and discuss the findings of this aspect of the study. In keeping with the research objectives, the findings of the antenatal and postnatal focus groups will be addressed individually and then the key findings highlighted and discussed.

5.2 Focus Group Methodology

As explained in Chapter Four, focus groups are regarded as cost effective, relatively easy to conduct and a quick way of obtaining information on a specific topic. Women were recruited to this element of the study from the preparation for parenthood course at the maternity unit. This excluded approximately 50% of women who do not attend antenatal classes at the hospital. A discussion outline was followed (see appendix V, and VII). The researcher who is a midwife acted as facilitator. This could have been a limitation to the study as women may perceive the facilitator as biased and it may interfere with group discussion and openness. Furthermore women may direct questions or defer to the facilitator and this may influence the flow and content of discussion.

5.2.1 The pilot of the focus group

The pilot of the focus group took place in March 1997 following the introductory session to parentcraft classes by the community midwife at a Health Centre. A group of eight women participated in the discussion. The pilot allowed the researcher to gain experience as a facilitator and to firm up the topic guidelines and analysis techniques.

5.2.2 The main focus group study

The antenatal focus groups took place in April 1997 and the postnatal groups met in July 1997. Three groups of women participated at both time points.

Group One: four women attended antenatally, three women postnatally

Group Two: five women antenatally, two women postnatally

Group Three: three women attended both groups.

In early June the delivery details of all the focus group participants were checked, primarily to ensure that all was well with the woman and her baby but also to be able to write and congratulate the woman on the birth of her son/daughter. Reminder letters about the postnatal focus groups and reply slips were sent to all the women 10 days in advance of the meeting (Appendix VI). The majority of women responded promptly. In Group One, one woman

did not attend the second focus group and in Group Two, three of the original participants did not attend the postnatal session.

Before each session, some informal discussion took place and refreshments were served before switching on the tape. This introductory period took from 5-15 minutes. Once the tape was switched on, the facilitator reiterated the aim of the group and asked individuals to introduce themselves for the benefit of the tape.

5.2.3 Group dynamics

All members of the focus groups had attended parentcraft and relaxation classes together prior to the initial focus group. As group dynamics is an important issue in analysis, it should be noted that these women knew each other and were part of a larger antenatal class group for at least 6 weeks. The group participants could not quite be described as friends, but in some instances the buds of a friendship appeared to exist. This was confirmed in the postnatal focus group where it became obvious that some group members had remained in contact. Prior to the focus group, the researcher found it helpful to allow the women time to chat amongst themselves whilst she 'busied' herself with other things, e.g. preparing refreshments, checking notes, 'talking' to the babies who had come with their mothers. This enabled her to see the group interaction in a more relaxed manner and anticipate group behaviour.

The perceived role, function and status of the facilitator may affect the outcome of focus groups. If the facilitator is seen to be associated with the organisation, or indeed is perceived as an expert on the topic, then the group may defer to the facilitator. This happened in a few instances during the focus groups, but in the main any questions or queries related to their own or their babies' well-being occurred either before or following the discussion. The perceived role, function and status of the facilitator could, if not handled properly, influence and bias the outcome of the discussion.

5.2.4 *Demographic data*

All women who attended were between twenty-four and thirty five years of age and were married or in stable relationships. All of the participants had attended the hospital antenatal clinic and their General Practitioner surgery for antenatal care. Two had Caesarean sections, three had forceps deliveries and the remainder had spontaneous vaginal deliveries. The minimum postnatal stay in hospital was two days and the maximum was seven days.

5.3 Findings

Data analysis underwent several stages and finally a condensed and succinct set of themes emerged. The common themes to emerge from the antenatal and postnatal focus groups are described in the following section. This chapter concludes by discussing the key issues to emerge from the focus groups.

5.3.1 *Common themes from the antenatal focus groups*

5.3.1.1 *Ante-natal Care and Preparation for Motherhood*

Views about antenatal care were mixed. Some women said that they didn't have a lot of faith in their General Practitioner but equally some who saw a midwife said the same. Those who experienced good professional support were happy. Doctors were not expected to respond to women's needs, they were considered to be too busy to spend time getting to know the woman. However the consensus seemed to be that the midwife would have the skills and time to nurture and provide professional support. When this did not happen women were upset:

> *"I still feel like I was treated like a number. Hearing the work done on woman centred care, I thought it was going to be different, but definitely not." (Focus Group One)*

Women admitted to not giving the postnatal period a lot of thought antenatally. Most felt that they *'didn't want to count their chickens'* and preferred to leave definite decisions about issues such as feeding to after the birth. As these women had never been mothers, they expressed the view that it was impossible to anticipate their educational and physical needs and emotional state antenatally, but

were confidant that following the birth these needs would be met. Women felt that the midwifery support and education in the postnatal ward would facilitate their transition to motherhood.

Practical advice about parenting was found to be lacking in the antenatal classes. Women said that although they saw a variety of professionals during the antenatal period, few had the opportunity to meet their community midwife if they attended the hospital clinic. On the whole women were unhappy with their antenatal care, in particular antenatal education.

> *"Antenatal care needs to be totally revamped. Parentcraft classes just repeated what the physio had said."*
> *(Focus Group One)*

> *"Remember the time she handed around a steam steriliser, we're not daft we've all read the books and been to Mothercare."* *(Focus Group Three)*

5.3.1.2 Support in the Postnatal Ward

Women expected that the midwives would act as teachers and facilitators during the stay in the postnatal ward.

> *"I'm expecting the midwives to come along regularly and say, "are you coping, are you doing fine?""*
> *(Focus Group One)*

Women said that they didn't really know what to anticipate following the birth of the baby but felt reassured that the midwives on the postnatal ward would be there to help, support and educate them. Women who expected support and education about breastfeeding and baby-care in particular, wondered whether their expectations were too high:

> *"Everyone says they're great but there's not as many of them as there should be* *(Focus Group Two)*

5.3.1.3 Time of Discharge from Hospital

Before labour, views about discharge differed from, *'as soon as possible'* to '*when the time is right*'. Women did not want to make any rash statements about optimum time of discharge. Indeed because there are so many variables about the delivery, the baby and feeding,

most women did not easily identify what an optimum time of discharge would be. Some women expressed concern about who would make the decision for them to go home. Some women felt that that whilst in hospital the midwives would be:

> *"checking on you and the baby, making sure that they can trust you."* *(Focus Group Two)*

This policing element was one identified by all women as a function of the staff in the postnatal ward. This seemed a popular view and no one expressed concern or doubt about this role, indeed for many women this was seen as their passport to motherhood. It was clear from all the focus groups that the women themselves were reluctant to say whether they would recognise when they were ready to go home. Women feared that midwives might not agree with their decision and this would result in them being perceived as poor mothers. One group thought that a positive outcome of hospital postnatal care was that they were more likely to get rest.

5.3.1.4 At Home

Before delivery, most of the women agreed that there had been little discussion about the postnatal period. Only brief mention was made at classes of the primary health care team and possible puerperal complications. Leaflets were given on postnatal depression and all of the women were aware of the third day blues. Women agreed that they had little knowledge of potential postnatal complications but felt that these would be identified in the postnatal ward. Most of them also felt that there was no point in worrying about things like postnatal depression, as they felt that there was little they could do to prevent it happening. When asked about the help that was required postnatally, most women said that they were anxious about their ability to cope with and baby and motherhood. It was spontaneously mentioned that a telephone number to phone for advice would be very welcome. The person women were likely to contact for support depended greatly on the reason for the call and their knowledge of the individual.

5.3.1.5 Postnatal Support at Home

In the antenatal focus groups all women agreed that some support would be available from their partners and in some instances relatives and friends had also said they would help. Women were reluctant to "count their chickens" and some expressed the view that the offers might never come to fruition. Partners were viewed as a mixed blessing and many of the women felt that they would help only in terms of baby-care. As many were intending to breastfeed, this would be minimal. All of the women agreed that actual concrete help in terms of washing, ironing, housework and cooking was unlikely. One woman asked whether during the fathers' class the midwives could stress to partners the importance of housework support for the women. The general feeling was that partners were more likely to listen to and act on the advice of the professionals.

> *"To be made aware by somebody else, not by the nagging partner."* *(Focus Group Three)*

5.3.1.6 The role of the Community Midwife

At the antenatal focus group women had a vague notion of the role and function of the community midwife. Only three of the women were familiar with their midwife, whilst another two women had had the midwife pointed out to them. The remainder had no idea who would visit, but agreed that it would be nice to have met the person beforehand. The facility of having a community midwife visit was viewed by all as welcome and her role was seen as adviser, mentor, counsellor and assessor. One woman said that she would:

> *"like someone to talk to her for a few minutes"*
> Whilst another
> *"felt it would be good to know you're doing things right."*
> *(Focus Group Three)*

5.3.1.7 Concerns of the Women

The women discussed their worries about the postnatal period and in particular the time after they got home. Interestingly most women felt that hospital postnatal care would prepare them for actually caring for

the baby, so baby care and feeding were not really a concern to them at this point in time.

Women wondered how they would get anything done. Shopping was a worry and the women agreed that the best thing would be to shop every couple of days. Women were acutely aware that they would have little time to themselves.

> *"What about the hairdressers?" (Focus Group Two)*
> *"Having a shower, time to go to the gym?" (Group One)*

The view was expressed that although partners had the right intentions they are "not in the same boat." Therefore, ultimately the responsibility for baby care rested with the woman. None of the groups felt that the partnership would be completely equal in terms of parenting.

A fear expressed by the women was the inability to cope with motherhood

> *"Who do you turn to when you can't cope, when you're left on your own? Everybody seems to cope. You don't hear about the people who suffer postnatal depression. If you can't cope you feel like some form of failure."*
> *(Focus Group Two)*

The women felt that what was presented in discussions about people's experiences of birth and motherhood were not a true reflection of what it was actually like. People rarely admit to not coping.

Other concerns expressed by women included how to comfort a crying baby, returning to work and infant care.

5.3.2 Postnatal focus group

5.3.2.1 Antenatal Care and Preparation for Motherhood

Practical advice about parenting was found to be lacking in the antenatal classes. With hindsight, women did not feel that the antenatal classes prepared them for motherhood and postnatal care. Examples of comments included:

"I don't think that the classes prepare you at all for it. I mean they give you a lot of useless information to be honest with you." *(Focus Group Three)*

Women said that they were not prepared physically or mentally for the demands of the puerperium and questioned why more education is not incorporated into the parentcraft classes. Women reiterated what they said in the antenatal sessions.

"Parentcraft classes just repeated what the physio had said." *(Focus Group One)*

Many women also said that the educational approach adopted by the midwives was patronising. It was considered that the classes did not devote enough time to postnatal care.

"someone like ourselves to come in and talk would be helpful."
"People should be saying more about breastfeeding and things – It's sore (breastfeeding) also, that you can bleed for a while afterwards and about how you will feel. You think it'll be fine cause of the way you're feeling now but you're not going to know how you'll feel after you've had the baby." *(Focus Group Two)*

"Tell the women you're never going to get your house work done ever again. *(Focus Group One)*

5.3.2.2 Postnatal Care in Hospital

Women had a clear vision of what they expected from hospital postnatal care. Some criticism was levelled at midwives for lack of help and support in the postnatal wards. Women viewed the midwives as gatekeepers, believing that they were assessing and observing the mother/baby interaction and would eventually base their decision about the time of discharge from hospital on their observations. In general, women did not remember their postnatal stay fondly and women had a variety of complaints about their time and care in hospital, although many of these complaints were interspersed with comments about midwives doing their best to support women. Three of the women said that hospital postnatal care was better than they anticipated.

"I thought I would be dying to get out, but I wasn't. I was quite happy to stay there because they were helpful and nice." *(Focus Group Three)*

The level and amount of noise generated in the postnatal ward was deemed unacceptable and inappropriate. Women complained about the constant ringing of the phone and other hospital noises, which prevented sleep even at night.

"I wasn't well rested in hospital, I had him (the baby) all the time, it was the noise of the phone ringing and everything else's. And just when you're getting to sleep, a killer. I could cope with him but I couldn't get any sleep because of the noise." *(Focus Group One)*

The amount of food was considered insufficient and in some instances was cold before the woman finished attending her baby. Breastfeeding mothers in particular said that they would have welcomed more food.

5.3.2.3 Support in the Postnatal Ward

After delivery, the view that hospital midwives are overworked was reinforced. Some women expressed concern about the midwife's introduction and orientation to the ward. Essential elements like ward routines, and for example, no mention of the siting of bathrooms and toilets, left many women stressed and wondering what to do. Some women expressed the view that they were not prepared physically and emotionally for the immediate postnatal period. Many women said that they had no idea that they would "bleed" so much after delivery. Women had anticipated more parentcraft education and supervision, but in reality these expectations were not met.

"Nobody told me where the toilet was, nobody told me where to find sanitary towel. Eventually I rang the bell, I was bleeding so much and I thought is this normal. Because I wasn't expecting to really, really bleed."
"Nobody showed me how to top-and-tail!"
(Focus Group Two)

"I know some of the women that were having problems felt very inadequate when they asked but I think I was lucky." *(Focus Group One)*

Women felt that those women who were breastfeeding got sufficient support with feeding, but education and support related to other aspects of mother and baby care was insufficient e.g., bathing and top-and-tailing. Women felt that when they expressed concerns about baby-care and coping with the baby the common refrain was "don't worry."

Most women who elected to breastfeed agreed that the physical support given to women by midwives was good but concern was expressed that insufficient detail about the actual process and physiology of breastfeeding was transmitted to women. Women said that it would have helped them to cope if reasons for not giving the baby a bottle were explained. Most women did not anticipate the feeling of extreme tiredness and exhaustion experienced in the immediate postnatal period. One woman, who stopped breastfeeding on the seventh day, blamed lack of support from the hospital midwives as the reason for stopping.

The consensus was that irrespective of the feeding method, rest was required after the delivery. It seems that bottle-feeders had the option of putting their babies into the nursery so the woman could have a sleep. Breast-feeders argued that they were not prepared for the demands of breastfeeding and in spite of the majority having attended breastfeeding workshops; the feeling was that the physical and emotional demands of breastfeeding were skimmed over in case it put people off. Taking a bottle-fed baby into the nursery may increase discontent with women trying to breastfeed. Extreme exhaustion combined with seeing well rested bottle-feeding mothers may in fact exacerbate the decision to change feeding methods.

The option of taking a baby to the nursery for the night will no longer exist for hospitals which have, or are applying for, the Baby Friendly Hospital Status. One woman said that she was refused a request to take her baby for the night. Her criticism of this was because midwives had not explained why giving the baby bottle feeds for a

night would interfere with breastfeeding. Many women expressed the view that midwives were very supportive at helping the baby 'fix on' but there was insufficient education and support centred on the maintenance of breastfeeding.

Irrespective of how they were feeding, women felt that mothers who choose to bottle-feed had the easier option. One woman who was bottle-feeding her baby told the group that on the first night her baby was taken away for the night and she woke up the next morning feeling rested and as 'fresh as a daisy'. Another woman had made a conscious decision before the birth to mix breast and bottle-feeding and right from delivery introduced bottles as well as breast. This, she felt, gave her the freedom that would otherwise have eluded her. At the postnatal meeting, her baby was seven weeks old and she was still breast/bottle feeding. She sometimes used expressed breast milk and at other times formula. Although women who chose to breastfeed said that it would have been easier to bottle feed, none regretted their decision to breastfeed. The only woman who expressed disappointment about feeding had changed from breast to bottle-feeding at day seven and had since regretted this decision.

5.3.2.4 The Delivery/Defusing

Although the focus groups postnatally did not set out specifically to examine women's delivery experience, all of the women wanted to describe and discuss their delivery. In some instances they kept returning to it and providing extra details. It was evident from the discussion that women would have welcomed an opportunity to discuss their delivery in retrospect with an attending midwife. The discussion of the delivery was cathartic. Some women said they had an easy delivery whilst others who experienced problems seemed puzzled about why they had experienced difficulties.

> *"I wish I had gone over the birth with someone who was actually in the delivery room with me to let me know the whole story. I wish some one had explained the problems I might have because of the forceps. I thought the pain would go away but it hasn't and I'm very cranky. I've*

just arranged to see a physiotherapist and hope that will help." *(Focus Group One)*

"They [the midwives] brought me down [from the labour ward] and then basically said – you know-"that's us" and handed you over to the other midwives and that was the last you saw of them."
"I was the same, she said that if she got a chance she'd come down at the weekend, but she didn't."

"I would have liked the opportunity to see the midwife again to discuss things." *(Focus Group Three)*

5.3.2.5 Time of Discharge from Hospital

Most women felt that the ward midwife had a policing role. In contrast to antenatal views, women felt that a professional opinion, rather than the individual woman's decision, was needed to inform their decision about when to go home from hospital.

> *"I think we need someone else's opinion because you don't know really what it's all about. You know if they say you can get out tomorrow if you want, and you think oh well I must be all right or something or maybe the baby's not all right and they say its up to you. You know I think you need somebody else to say."*
> *(Focus Group Three)*

Women agreed that they wanted the midwife to advise on issues and not leave the decision making solely up to them. Apart from the women delivered by Caesarean section, most of the participants were discharged from hospital on the third or fourth day. A high proportion of the women expressed the view that they were keen to get home for a rest. In general, the postnatal ward was found noisy and lacking in the kind of support anticipated by the women. Equally women wanted to get home and settle into a routine as none felt that there was an opportunity to establish any form of routine in hospital. Women felt that hospital routines and agendas took priority over their personal routines. Women who had longer hospital postnatal stays justified this by saying that they needed support with breastfeeding.

5.3.2.6 At Home

All women who participated in the postnatal focus groups agreed that if a woman had met her midwife prior to discharge home then she would feel more confident about phoning her for advice. If this was not the case and depending on the problem, a General Practitioner, relative or friend would be contacted. Knowing the community midwife prior to discharge postnatally was seen by all women as an asset. Those women who knew their community midwife had fewer concerns about allowing her to visit them at home than the others.

By the time of discharge most women felt that they were ready to go home. Two women said that their homecoming was worse than anticipated, as their partners had not prepared the house for them. Both women said that they had been explicit in their instruction to their partners, but to no avail. One woman described her homecoming as a 'disaster'. Her husband had promised to sort things out but had forgotten to sterilise the bottles and they had a very upset baby for the two hours it took them to prepare the feed. Another woman said that she walked in the door and five minutes later burst into tears. It was acknowledged that hormones probably play a major role at this time and many felt that it is impossible to anticipate this. The extensive demands of the baby were more than anticipated by many women. All the women said that emotional impact of being completely responsible for the baby, combined with the demands of feeding and looking after the baby had consequences that they had not anticipated.

> *"I feel tired at certain points during the day and I think, God I can't face this and then you do and you just get over and get on."* *(Focus Group Three)*

> *"It was the kind of not knowing if she was warm enough, not knowing if she was settled."* *(Focus Group Two)*

> *"She's up during the night three or four times, when she was up every three hours that was the hardest thing, you were kinda falling asleep. She doesn't sleep too much during the day. It's hard to try to keep her happy. Then you go to peel the potatoes then she cries and you have to go back to her."* *(Focus Group Two)*

5.3.2.7 Postnatal Support at Home

Visitors were seen as a mixed blessing and the impact of their visit very much depended on who the visitor was and the perceived reason for the visit. One woman confessed to not really wanting people to visit, as she was afraid that the baby would start crying and she would not be able to stop him. She 'would get into a real state'. Most women felt that visitors only came to see the baby and weren't interested in how the woman was getting on.

> *"Nobody asked if I wanted help, nobody was interested."*
> *(Focus Group One)*

> *"I did find that when people came to visit they really only came to see her."*

> *"Nobody said to me, "Do you want to do the ironing?" If they took her to keep her amused I'd be quite happy, but nobody did volunteer anyway. Nobody said, "Do you want me to do the dishes?""*

> *"I know, nobody offered to do anything."*

> *"Even just someone to take them away for a walk for an hour. You know if they were screaming their head off, just to give you some peace."* *(Focus Group Two)*

Many of the women admitted to having their own coping strategies to deal with visitors. This varied from requesting that visitors stay away for the first two weeks to limiting the nature and number of visitors, although it was acknowledged that this was difficult to achieve.

> *"...was off for the first two weeks after I came out of hospital, so the people that were phoning were just asked to stay away and I think that's what definitely made a difference."* *(Focus Group Three)*

Although most women said that they had support when they came home from hospital, it was sometimes of a limited nature. Most women felt that as it was their baby they should be able to cope themselves and were reluctant to accept offers of help from family and friends. They also discussed the nature of the support offered and acknowledged that the majority of help offered was related to baby care although many would have appreciated help with housework.

"My husband comes home and takes him. I put on washings etc, and then he says, "I thought you were having a bath. I say, I know but I thought I'd do this first." It's a vicious cycle."

"I'm getting help from Mum and my boyfriend but when they've got him [the baby] I'm trying to catch up on housework." *(Focus Group Three)*

Women agreed that establishing a routine is difficult, as baby behaviour was unpredictable.

5.3.2.8 The Role of the Community Midwife

All women said that they found the midwife visits helpful. Most women said that more than one community midwife visited them at home.

"There were two different ones and it was good knowing that they were coming in and they would say to me "do you want me to come tomorrow or the next day?" They were fine" *(Focus Group One)*

In some cases this led to conflicting advice and inadequate support. One woman said that in a case of conflicting advice she would 'go with the one she liked'. The issue of conflicting advice seemed to centre on particular issues such as:

- Breastfeeding and related issues
- Use of dummies
- Cord care

One woman discussed the opposing views many midwives held about the use of pacifiers. She had also experienced this conflict with other professionals as well.

"My General Practitioner said, "Give her a dummy" (I was breastfeeding). I told him that the midwife had said, "No" and he says, "Why do they make it hard for you?"
(Focus Group One)

(She took the General Practitioner's advice and was delighted).

"I think, well they gave you different opinions on things, you know just wee things that they'd mention and you'd think that's not what the other one said, but because I

liked one better, I'd just go with what she said. I suppose it does affect you because you're not too confident."
(Focus Group Three)

"When I was asking for information on breastfeeding, I would see one midwife one day then the following day it would be totally different information ... at the time it was the one thing that annoyed me". (Focus Group Three)

When women received conflicting advice, this resulted in confusion and stress. Whilst women accepted the difficulty of conflicting advice it was stressed that new mothers need consistent information from professionals. Women said that it was better if they had met the midwife/ves antenatally.

"I probably would have preferred if it had been just the one that came to see me but since I had known both of them before the baby was due it wasn't that bad."
(Focus Group Three)

"Well I knew my midwife, but she was actually off for the first couple of days, so I got another midwife and she was really nice." *(Focus Group Two)*

Some women felt that midwives should have explained things better to them.

"I had problems feeding her and they kept saying "Oh this is a growth spurt," and they never explained what it meant. It was my Health Visitor who explained. I didn't know if it was something that lasted for an hour or she wasn't getting enough milk." (Focus Group One)

Most of the women valued the midwives visits.

"It was actually a bonus coming in [the midwife] because I could ask about anything that was worrying me like the cord coming off." (Focus Group One)

The midwife's visits were generally regarded as helpful although some women felt that negotiating an approximate time of the visit would be useful. Women felt that the midwives expected them to be in whatever hour of the day they called and that this was not always convenient. Some women felt that it would be useful if midwives continued to visit for longer. Some midwives gave women a contact number, but it

depended how the phone contact was initially described, whether the woman felt comfortable to use it.

> *"The midwife gave me a phone number but it was like – "this is where you can get me but it's very busy." If they said, "it's a twenty-four hour number" then you'd feel more confident to use it." (Focus Group Two)*

5.3.2.9 Midwives' Understanding of the Impact of Motherhood

In the postnatal groups, women, reflected on whether midwives understood what they, as new mothers, were going through. Women thought that many midwives were not in touch with what it is like to be a new mother. The view that midwives did not always listen to women was reflected in the fact that instead of offering advice, support and praise, they sometimes used what could be termed as platitudes like "don't worry you'll be fine." This did not help the new mothers and did not increase their confidence. Women also mentioned that midwives sometimes have unrealistic expectations of motherhood.

> *"Hospital midwives said things like "when you get home, put your feet up and get plenty of rest. That's a laugh." (Focus Group Three)*

Many women felt that rest was unachievable and to even suggest such a thing hinted at ignorance of early parenthood.

Women were concerned that midwives seemed to lack insight into early motherhood. The conflicting advice experienced by some women suggested to them a lack of sound knowledge on the midwives part and resulted in women feeling less confident in these midwives.

5.3.2.10 Postnatal Concerns of the Women

Much of the postnatal discussion centred around the notion of coping and being a 'good' mother. They reiterated what they said antenatally, concerning coping with a crying baby, fear of cot death and returning to work. Women were concerned about leaving the baby and returning to work. Those that planned to return to work soon had baby care arranged, but all admitted that going back to work caused them some anxiety.

5.3.2.11 Experiences of and Reactions to Motherhood

All women admitted to finding motherhood harder, but also far more rewarding, than anticipated.

> *"He's quite a contented baby and I find it rewarding."*
> *"People keep saying you forget [the delivery] but I don't think you forget. I think it just isn't important because you have this wonderful wee thing." (Focus Group One)*

The general agreement was that "you take the good times with the bad." Many of the women mentioned that the extreme tiredness associated with early motherhood was unanticipated, but the majority agreed that by six weeks postnatally things were improving. The feeling of exhaustion and helplessness had made some mothers feel very low at times. Some women felt that their mental state made early motherhood more difficult.

> *"I feel as thick as two short planks. Honestly I can't hold a conversation with people. He's seven weeks now and I'm talking to people and I forget half way through. I was never like that before. My brain is scrambled, chasing my tail trying to find where I put things two minutes before." (Focus Group Three)*

> *"I'm getting better, but if I'm very tired or feeling low, it really - I have horrible, horrible thoughts and it really depresses me, in fact I've found myself sitting in tears about it... It comes and goes. I just keeping talking to people about it and they say, —Oh we felt like that and it wears off. So it's good to hear people say," it's normal that's how I felt."" (Focus Group One)*

Getting to know their babies and their different cries was an element of motherhood that women experienced but had not anticipated. Most women felt that it took up to six weeks in some cases to really get to know the baby. However all said that they could decipher the cries much quicker than the fathers could.

> *"It's only recently I've started to, (know the cry) even now I don't know all the cries only the hungry, girny cries." (Focus Group One)*

> *"Now I can tell when he's crying cause he's tired. It's just in the last week or so I could tell that."*

"When she's crying, I'll say She's just tired, but [partner] will say, For Gods sake that's her crying again, and I'll say, but, she's just tired."

(Focus Group Three)

One woman said that when her son was born she didn't know if she liked him, but once she spent some time with him things changed.

"When I had him all I wanted to do was sleep. I didn't know if I liked that baby. I wasn't prepared for that I thought when you had your baby, you know because, for carrying it for nine months you were going to love your baby."

(Focus Group Two)

There were murmurings of agreement from the other two women present. Women were primarily concerned with '*being a good mother*' although perceptions of what this actually meant differed.

Some women felt that their weight loss was not as rapid as they had anticipated and two women said that they needed to '*get rid of their stomachs*'. Two admitted to feeling awful but both these women had ongoing infections (one = perineal, one = intrauterine). Only one said that she felt the same as before the pregnancy. Some women said that their state of well-being depended greatly on the amount of sleep they had. Those women who breastfed complained of being more exhausted than those who bottle-fed their babies. Women in each of the three postnatal groups shared the concerns about postnatal care. All three groups and women agreed that antenatal care and preparation for parenthood should be improved.

"Maybe it's a personal thing but people should be telling you that breastfeeding is sore and things like you're going to bleed really heavily for three or four days."
"Nobody tells you that – nobody told me."

(Focus Group One)

"I think that antenatal care needs to be totally revamped."

(Focus Group Three)

Initial priorities following discharge alter over the weeks. Initially women said that they put all the emphasis on the baby with little

attention to themselves, but as the weeks progress it dawns on mothers that they need to be healthy and well fed.

> *"Whereas now I stick the dummy in her mouth and eat my dinner, then, I would feed her. I know her better now."*
> *(Focus Group One)*

Before the birth all groups admitted that they had not thought very much about the postnatal period and agreed that their main concern was getting over the delivery and having a healthy baby. Following delivery most women said that things were not as they anticipated and that they felt inadequately prepared. The one woman who bottle-fed exclusively from the birth of her baby was the only one to be completely satisfied with all elements of her care. Most of the remainder were dissatisfied with elements of their hospital postnatal care.

5.4 Discussion Of Findings

5.4.1 Preparation for parenthood

All of the women agreed that they were not prepared for the puerperium and said that antenatal education was inadequate. Many women stated that antenatal classes did not adequately prepare them for parenthood. These concerns have been found by other authors (Gould, 1986; Hillan, 1991; O' Meara, 1993) and even following the stay in the postnatal ward some did not feel prepared for their role as mothers. Anticipating what to expect should allow a new mother to plan ahead and identify limitations and avoid feelings of inadequacy (DiMatteo, Kahn & Berry, 1993).

This study, although localised to one maternity teaching hospital, supports the view that antenatally, women place little emphasis on the postnatal period (Nolan, 1995). There is now recognition that the health education needs of new mothers are not completely addressed by prenatal education classes (Moran et al, 1997). Antenatal focus groups found that women did not consider the postnatal period in detail. Although they knew in advance that the focus group was on the subject of postnatal care, the discussion highlighted that little thought had been given to it, possibly reflecting the lack of interest

that antenatal women seem to have in postnatal care. Postnatally, women asked why insufficient preparation for motherhood existed. The conundrum is how to persuade women to accept that they should seek and absorb information on postnatal care in the antenatal period when they do not see it as a priority. It appears that pregnant woman think the postnatal period contains many variables making it impossible to anticipate issues concerned with postnatal care. Concerns about the delivery, neonatal health, feeding, general infant demeanour and maternal well-being, all take priority over plans for the puerperium. As all these women were expecting their first baby and they expressed caution about making plans for after the birth. Women did not want to 'count their chickens' about issues relating to the delivery and the well-being of the baby and themselves postnatally. These 'ifs' and 'buts' mean that many women are unsure of themselves postnatally. All those who participated in the focus groups were confident that any gaps in their knowledge and experience would be adequately filled by midwifery staff in the postnatal ward. This 'blind' acceptance of the support they would get seemed to ignore other comments they made about ward staff being very busy. A larger study by Small, Astbury & Brown (1994,) found that women were dissatisfied with childbirth education as a preparation for parenthood. But, childbirth educators point out that the difficulty in preparing first time mothers for motherhood is the magnitude of birth itself - long awaited, desired, and feared, unknown and unknowable - blocking out the future (Evans, 1991; Nolan, 1995).

Evidence from other studies suggests that in spite of educational strategies primigravid women have a tendency to postpone decision-making about the postnatal period (Evans, 1991; Handfield & Bell, 1995; Nichols, 1995). Women are unsure of what to expect and therefore avoid making any firm plans about the baby in case they cannot be achieved. Women are afraid to make plans in case they are tempting fate and something happens to the baby. There is evidence to support the view that pregnant women are not interested in postnatal concerns (Nolan, 1995, Handfield & Bell 1995). Little has been done to alter the balance. The women in this study agreed that expectant women should be forewarned about the puerperium, but were unsure how to

do so. One suggestion was to have postnatal women come and talk to them prior to labour and delivery about what life is like following the birth.

Priorities that exist antenatally fade into insignificance postnatally. Women appear to have no expectation of how they will feel postnatally. Nothing prepares them for the emotions, workload, and exhaustion which impact on physical and emotional well-being postnatally. Whether the approach adopted by pregnant women is an in-built protective mechanism or part of our culture remains to be seen. What is clear is that some attention must be paid to antenatal preparation, so that a more focussed consumer led educational service is provided.

5.4.2 Stay in hospital

Although many women had not expected to find their postnatal stay enjoyable, some found it better than they anticipated. In keeping with other studies many criticisms centred on the quality of the food, the noise and inability to rest (Audit Commission, 1997; Lothian Health Council, 1992). Women who were in four-bedded rooms were anxious in case their babies disturbed the others.

Feelings about hospital stay centred around the degree of rest, together with support and help given to them by the midwives. Women wanted to use their stay in hospital to learn about baby care and establish feeding. All agreed that getting rest was a priority but only one woman (who bottle fed) said she came out of hospital well rested. A second objective for women was to learn about baby care and develop confidence in caring for and feeding the baby. Many women were disillusioned with the education and support they received, but as they perceived the midwives to be very busy, it may be that they did not ask for help. This concurs with the findings of Marchant (1997). Other studies (Singh & Newburn, 2000) highlighted that women wanted more information and emotional support during the immediate time following the birth.

5.4.3. Midwives in the postnatal ward

Although not an intention of the study the focus group discussions revealed interesting views about the role of midwives in the postnatal ward. Despite

antenatal preparation for motherhood, many parents feel ill equipped to care for their newly born baby (Garcia 1997). Garcia (1997) argues that the role of the midwife has shifted towards meeting these needs and increasing the parents' own confidence in their ability to cope on their own. This argument was substantiated by this study but an interesting adjunct was that the women viewed midwives in postnatal wards as gatekeepers. The consensus was that hospital midwives observed and assessed mother - baby interactions and made decisions about the time of discharge on that basis. Midwives were expected to identify whether mothers were coping and fit to go home. For this reason, women were afraid to ask to go home and/or when they might expect to be discharged in case this was seen as inappropriate. It was agreed that a professional view of whether a woman was 'fit' to go home was required. The term "fit" was used to cover many aspects of motherhood. Women were concerned that they would be good mothers and be able to cope with the baby.

All of the women in the antenatal groups felt that midwives in the postnatal ward might be too busy to help them as they are overworked. The majority of women expressed the notion that all hospital midwives were 'very busy' - a common perception amongst women (Marchant, 1997). It seems that this belief is absorbed from a variety of sources such as media, parentcraft educators, midwives, doctors, other health care professionals, peers, family and friends. In a recent NCT study sixty percent of women did not think that there were always enough midwives to care for them in the initial days following the birth (Singh & Newburn, 2000). In many instances, this anticipation that the midwife will be busy, becomes a self-fulfilling prophecy. The role of the midwife should centre on providing education, support and increasing maternal confidence in her ability to care for the baby. However, the belief that hospital midwives are overworked may inhibit women from asking for the education and support they need.

5.4.4 Support at home

Before the birth women seemed happy with the potential support available and none of those who participated in the focus groups expressed concern about insufficient support. One antenatal group felt that professionals should explain

to partners that the support they offer be of a practical nature. The consensus was that the partners should help with the baby but might be more reluctant to offer concrete support in terms of housework and ironing. Although women felt that they would get help and postnatal support from family, friends and partners, many felt that these were token gestures. Visitors came to see the baby, had little real interest in the mother and, if anything, created work. Women felt that visitors expected to be entertained 'like before.' Interestingly women felt that even if offers of help to do the ironing and other tasks had been volunteered, they would have refused, as this would be seen as an admission of being unable to cope. However, they would have accepted offers of help to care for the baby in order to allow them to get on with the housework.

Once home, although all women had some form of support and help, some still insisted that some things were best done by themselves. So, although women say they have support and the help of partners, many felt that the standard of work carried out by their partners was unacceptable.

All women identified the need to have a maternal figure with whom to discuss things and those who did not have this, highlighted their loss

"I miss my Mum for somebody to speak to."

Social support by lay or professional people has been found to have positive effects on maternal well-being (Elbourne, Oakley & Chalmers, 1990) although a recent randomised controlled trail of social support for postnatal women found that there was no change in outcomes between the groups (Morrell et al, 2000). A possible reason for this might be the lack of a defined effective model for emotional, social and practical support for new mothers (Morrell et al, 1997).

5.4.5 Sources of advice and support

If problems arose, the person women would go to, depended on the nature of the problem. It was acknowledged that, where possible, women would avoid seeking professional advice, however if a woman knew her midwife antenatally, then for health related problems of mother/baby she might

contact her first. If the midwife was not known, then a woman was likely to approach her General Practitioner or a friend. Friends and family were the first port of call for what the women described as 'minor worries'. All women, irrespective of social/educational background, expressed a fear of seeming inadequate if they asked professionals 'silly' questions. MacArthur et al, (1991) concur that many women do not seek professional help for health problems in the postnatal period. The reluctance to seek professional advice seems to be rooted in a fundamental lack of confidence by new mothers. Knowing the professional, made it easier for personal contact in times of worry.

5.4.6 Postnatal defusing

Although not a research objective, all of the women wanted to discuss in some detail their delivery experience and frequently brought the discussion round to the delivery, if enough attention had not been given to it at the beginning of the focus group. Evidence suggests that women should be given the opportunity to discuss their labour and birth postnatally (Hunter, 1994). This is not only cathartic but also allows the woman to make sense of her experience. Debriefing can be an effective risk management tool and a therapeutic avenue for the woman, (Lavender & Walkinshaw, 1998) yet in spite of the evidence this is not a facility freely available to all postnatal women. All women in the study said they would have welcomed the opportunity to discuss the labour and delivery after the birth and many were still concerned about aspects of their delivery.

5.4.7 Experiences of motherhood

Certain aspects of motherhood took the women by surprise. Getting to know the baby was an issue highlighted in the postnatal focus group. Many women were surprised that they did not automatically bond with, or love, the baby. Some were surprised that each baby had a personality of its own. Women expected instinctively to understand their babies' needs and were surprised that it took them some time to get to know their babies. Indeed, recognising the different cries took the women up to six weeks to learn. Some mothers said that they could decipher the cries, but they were still a mystery for the fathers. Little has been reported about women's experiences of getting to

know the baby although it may be that this element is encompassed under the heading of bonding, mother–infant attachment, and becoming a family (Martell, 1998; Rogan et al, 1997).

The complex emotions that women experience postnatally, coupled with extreme exhaustion and the obvious changes associated with parenthood, are rarely verbalised by childbirth educators (Nolan, 1995). Women felt that the opportunity to talk with new mothers about their experiences would have been helpful.

In general, women did not anticipate the impact that feeling tired would have. Although all of the women said that they expected to feel tired, the majority said that they had not expected such levels of chronic exhaustion and tiredness. Tiredness was recognised as a pervasive problem amongst all postnatal women irrespective of parity and delivery method (Glasener et al, (1995); Brown & Lumley (1998). In this study this was particularly noticeable in women who were breast-feeding. Many felt that if they had been allowed a good night's sleep after delivery, this would have prepared them for the weeks ahead.

Overwhelmingly, mothers in this study - irrespective of age or social class were concerned about 'being a good mother' and incorporated into this was a desire to balance all elements of motherhood. Other studies concur that women have a variety of complex concerns varying from being a good mother to maintaining a degree of independence (Smith, 1989; Hiser, 1987; Mercer, 1985).

5.4.8 Emotional well-being

Some mention is made in the literature and in all the classic textbooks about the "third day blues" and the effects of hormonal changes on the woman in the postnatal period. Yet, little or no mention is made of the other effects of childbirth. All of the women in this study admitted to not feeling in as much control postnatally as antenatally. Some women admitted that they found it difficult to concentrate or make simple decisions. All complained that their

confidence levels were much less than before the birth. Brown et al, (1994) found that over half the postnatal women they interviewed believed that their confidence had been adversely affected since becoming a mother. Women had not anticipated the impact that motherhood would have on their confidence level and decision making skills but expressed relief that others in the group had similar experiences.

The women in this study said that tiredness definitely impacted on how they were coping and feeling and felt that they did not receive any worthwhile advice from the professionals on this matter. Singh and Newburn (2000) agree with this finding and stress that professionals should be aware of the needs of both the woman and her partner in the postnatal period and discuss with them the importance of getting enough sleep, minimising the housework and having emotional support.

5.4.9 Community midwives

Some women were of the view that it might have been helpful to have the community midwife visit for longer after discharge even up to six weeks 'just to keep an eye on things'. The value of the community midwives seemed directly proportional to the requirements of the woman and whether she knew the midwife. Although all women said that more than one midwife visited them at home, none were unduly perturbed by this unless there was evidence of conflicting advice. In these cases the women admitted to accepting the advice which either suited them, or, was given by the midwife they liked best. The midwives personal relationship with the woman played a key role in how the woman perceived her care (Shields et al, 1997). If the woman had met the midwife antenatally, the relationship was generally very good. Women felt that knowing the midwife beforehand meant that the midwife knew the 'real' person rather than the emotional first-time mother that now existed. This finding concurs with other studies such as Rennie et al (1998), which established that women like to know the midwife who will care for them in their own home postnatally.

Although there has been little work to investigate the role of the community midwife in the postnatal period, a recent survey of women's experiences of postnatal care which was completed by the National Childbirth Trust, (Singh & Newburn, 2000) established that care from the community midwives from four to ten days after giving birth is rated more positively than immediately after birth when most women are in hospital, or after ten days, when access to the community midwife is reduced or no longer available.

5.4.10 Conflicting and inconsistent advice

In keeping with recent work, (Singh & Newburn, 2000) women said that, given the opportunity, they would have liked to be visited by the same midwife, as this would lessen the chance of conflicting advice and information. Conflicting advice is stressful for woman in the postnatal period. All want to do 'the best thing' and become easily confused when bombarded by different views (Audit Commission, 1997, Singh & Newburn, 2000). In some cases the differences were minor and reflected personal preferences such as the type of baby cream to use. However, even an issue of such apparent insignificance can cause considerable stress to a new mother. Midwives and other health care professionals must be vigilant and, where at all possible, avoid giving opposite views. Many professionals knowingly give differing, if not necessarily conflicting, advice. Some give this advice with the best of intentions, knowing that the information they are giving is accurate and evidence based. Others are not so altruistic. (Brown et al, 1994) state that advice is rarely offered in the form of suggestions – 'try this'- but as a confusing series of solutions, given with inappropriate certainty by the parade of passing experts. The NCT concluded that particular attention should be paid to providing consistent advice and information to new mothers (Singh & Newburn, 2000).

5.5 Conclusion

The study found women's perceptions and expectations of postnatal care shift following delivery. Before birth, apart from deciding the feeding method, women are slow to identify their expectations of postnatal care, mainly due to the diversity of variables, which may influence the outcome. The evidence

presented suggests that in spite of attempts to increase the profile of postnatal care, it remains a low-key element of maternity care for both women and professionals. Women said that they were not prepared physically or mentally for the demands of the puerperium and questioned why more education was not incorporated into the parentcraft classes.

Other studies highlight that hospital postnatal care is limited in its ability to prepare women for the early weeks of motherhood (Crouch & Manderson, 1993; Singh & Newburn, 2000). Women criticised the lack of education and support for new mothers, especially whilst in hospital. In the postnatal focus groups, women indicated their priorities for postnatal care. This included information about postnatal complications, infant illness, and education on baby care, in particular infant feeding and infant behaviour. Other studies support the view that baby care concerns are a priority to all women (Davis, Brucker & MacMullen, 1988; Martell, Imle, Horwitz & Wheeler, 1989).

Anxieties about motherhood and coping with the changes, which occur, were also highlighted. Although an everyday occurrence to midwives, the birth and subsequent care is the single most important thing for a new mother. Morales-Mann (1989) found that nurses gave priority to physical care activities while new mothers considered teaching and psychosocial care as important. Laryea (1989) found fundamental differences in the way midwives and mothers defined motherhood. Midwives emphasised biological aspects of motherhood seeing it as a normal process in a woman's life-cycle and an indication that she has achieved physical maturity with care focusing on the physical. Mothers, whilst also equating motherhood with the achievement of femininity, placed emphasis on the social perspective, speaking of an acquisition of a new role.

The plethora of conflicting and inconsistent advice continues to be a concern. Health care professionals should introduce strategies to reduce the discrepancies in advice. A principal concern for women is being a good mother, however the definition of being a good mother varies from woman to woman. (Small et al, 1994). Women identified 'being able to cope' as an integral component of motherhood. The available literature on coping

strategies used by postnatal women suggests that they tend to rely on their own resources and support network. Although women identified potential sources of support antenatally, after delivery, women were less sure and less confident about accepting help from others. For many, accepting help was seen as an admission of failure or an inability to cope. The postnatal mothers said that they just 'get on with things'. Implicit in some discussions was the notion of the rather limited role of the partner. Although women were quick to stress that their partners were help, they quickly agreed that their role was very restricted.

Postnatal debriefing was identified as a gap in care. During the postnatal focus groups, women used every opportunity possible to discuss their experiences of labour. Nobody in the study had a formal debriefing but two women met the midwives who delivered them and used the opportunity to discuss their labour.

This study identified that women in this study had similar concerns to those identified in other studies (Brown et al, 1994). Moreover, women were not always prepared for the magnitude of motherhood and faced continual concerns about their ability to cope and be a good mother (Martell, 1998). Women identified the need for a peer who had been through the experience of childbirth to support them postnatally. The notion of providing each postnatal woman with a 'friend' who could provide support during the first few weeks postnatally was accepted as a valuable resource.

In keeping with other studies (Bostock, 1993), antenatal women had the idea that hospital midwives were very busy. This view was ratified postnatally when women established that the basic education and support they anticipated postnatally did not come to fruition. Community midwives were not perceived in the same way, although women agreed that knowing their midwife would make community postnatal care more effective and less stressful.

CHAPTER SIX

RESULTS OF THE BEFORE AND AFTER STUDY

This chapter presents the findings of the before and after study which introduced a new model of community postnatal visiting. The first part of the chapter describes and compares the results of the anonymous questionnaire which was distributed to all community midwives in August 1997 when the traditional model of care was being evaluated and in June 1998 three months after the introduction of the new model of postnatal care.

The second part of the chapter describes and compares the results of the postal questionnaires which were distributed to postnatal women between May and September 1997 and February and June 1998.

6.1 PART 1: COMMUNITY MIDWIVES' PERCEPTIONS OF THE SUPPORT THEY OFFER POSTNATAL WOMEN

When examining change in maternity services, it is important to consider the impact of the change on those who will be directly affected by it. In the current study, midwives working in the community were most likely to be affected by the introduction of the new postnatal care model, therefore it was decided to examine the impact of the change by measuring satisfaction and the impact of the new model on their workload. Community midwives have a different working day to those working in a hospital setting. Postnatal care is just one element of the role of the community midwife. Community midwives are responsible for antenatal care both in health centres and general practitioner surgeries as well as in the home. They may also be involved in parentcraft education programmes.

6.1.1 Aim and objectives

The aim of the study was to examine community midwives' perceptions of, and satisfaction with, the postnatal support they offer women. The specific objectives were to:

1 Examine midwives perceptions of their role and the postnatal support provided to women following discharge from hospital;
2 To compare midwives satisfaction with the two models of community based postnatal care provision;
3 To identify factors which influence midwives' decision making about the organisation, planning and content of postnatal visits to women.

6.1.2 Method

The information for this part of the study was obtained from anonymous questionnaires sent to all community midwives (n=20) working in the study hospital. Questionnaires were sent at two time points: in August 1997 during Phase 1 (when the traditional model of care was being evaluated) and in June 1998 during Phase 3, three months after the introduction of the new model of postnatal care (Appendix IX & X).

Anonymous, rather than confidential, questionnaires were used as it was felt that midwives were more likely to be frank in their responses to the questions if they knew that their identity was completely protected. The questionnaire consisted of mainly closed questions and a series of Likert-type statements derived from a previously validated questionnaire to examine midwives attitudes to woman centred care (Hillan et al, 1997). A covering letter was sent with the questionnaire explaining the purpose of the study and that as it was anonymous any responses could not be attributed to individual midwives.

6.1.3 Statistical analysis

Careful attention was paid to the types of statistical tests which were used as the number of midwives was small n=20, and the questionnaires were anonymous. As explained in Chapter Four for categorical variables, when the sample is not large (twenty or less) and expected values are less than 5, a Fishers Exact Test was employed. The Fishers Exact test determines the exact probability of obtaining the observed result or one more extreme, if the two variables are independent and the marginal totals are fixed (Puri, 1996).

As Chapter Four explained the midwives questionnaires were anonymous (pairs could not be matched) so it was not possible to use the Wilcoxon

matched pairs test to examine the difference between midwives responses to the Likert style questions. The Mann Whitney U test was used to examine the difference between midwives' answers to the Likert style questions. It is an appropriate application as the categories are ordered and can be used as a replacement for the X^2 Test. The only assumption required about the distribution of the data is that the observations must be ranked, as is the case with Likert responses (Bland, 1987).

6.1.4 Presentation of findings

For ease of presentation the demographic characteristics and background information presented is from the findings of Phase 1 questionnaire - as in all instances findings from both questionnaires were similar. A similar approach is taken to describing postnatal workload and factors which influence decisions about community postnatal visits. The rest of the results from this part of the study describe and compare the findings of Phase 1 and Phase 3.

6.1.5 Response rate

Of the twenty questionnaires distributed in both Phases of the study, sixteen were returned in Phase 1 and fifteen in Phase 3. As the questionnaires were anonymous it was not possible to examine the characteristics of respondents and non-respondents. However, the demographic characteristics and baseline data from both groups were similar and apart from maternity leave during Phase 1 (these midwives were sent questionnaires to their own homes) there were no staff changes in the time period between the distribution of the first and second questionnaires.

6.1.6 Demographic characteristics of respondents

Table 6.1.6 shows the demographic characteristics of respondents to the initial questionnaire. All but one of the community midwives who responded were working as G grades. The mean age of the sample was 37.4 years and the mean length of time in practice as a midwife was 12.8 years. Twelve midwives worked full-time and the remaining four worked part-time.

Table 6.1.6: Demographic characteristics of respondents

Variable		Findings
Age	Mean (years) Range (years) SD	37.4 31-50 5.6
Employment	Full time Part time	12 4
Length of time in practice	Mean (years) Range (years) SD	12.8 6-24 4.8
Length of time in community	Mean (years) Range (years) SD	5.9 1-21 4.7

6.1.7 Current work commitments of respondents

The midwives were asked a number of questions about their current work commitments and the responses are shown in Table 6.5. Only a small proportion of women in the study hospital book for a home confinement each year, therefore it was perhaps not surprising that the average number of home births attended by midwives was only one point six (range 0-3). The number of women booked for DOMINO birth, where the community midwife delivers the woman in hospital and discharges her home within eight hours, is higher. Community midwives attended an average of three point three DOMINO births per year (range 1-8).

Despite the relatively small number of home and DOMINO births, some midwives said that they had a relatively large 'on-call' commitment with an average of 88.5 hours 'on-call' per two week period (range 24-144 hours, SD 39.1). This high 'on call' figure includes midwives routine 'on call' commitment during their normal working day and midwives who are second on call. Furthermore, each team goes 'on call' for a three month period for all DOMINO and home confinements (irrespective of geographical area). When midwives were asked how frequently they were required to be on-call there was considerable variation in the responses (Table 6.1.7). It is not possible to fully explain the variation in 'on call' commitment by midwives, but influencing factors appear to be midwives who worked part-time, the numbers of DOMINO and home confinements due and in some instances midwives personal commitment to specific women for whom they were caring.

Table 6.1.7: Current work commitments

Variable		Findings
Frequency of on-call commitments	Fortnightly Monthly Other (6/52-3/12)	4 8 4
No of on-call hours per fortnight	Mean (hours) Range (hours) SD	88.5 24-144 39.1
No of DOMINO births	Mean Range	3.3 1-8
No of Home births	Mean Range	1.6 0-3

6.1.8 Current postnatal workload

Midwives were asked a number of questions about their involvement in postnatal care (as opposed to other activities) and the responses are shown in Table 6.1.8a. The respondents in Phase 1 stated that they made an average of seven postnatal visits each day (range 6 to 8) and those in Phase 3 said that they made approximately six postnatal visits. This accounted for approximately 60% and 50% respectively of their working time. Fourteen of the respondents felt that women got enough support from midwives after discharge from hospital and when asked to rate the quality of postnatal care given to women thirteen midwives rated it as excellent or good. As it is not possible to determine the duration of each postnatal visit from any of the available records, midwives were asked to specify the average duration of a postnatal visit to a low-risk primigravida. In both phases the average duration was twenty minutes (range 15-30 minutes).

Table 6.1.8a: Current postnatal workload

Variable		Findings
No of postnatal visits per day	Mean Range SD	7 6-8 0.8
Proportion of day spent on postnatal care	Mean Range	60% 50-75
Length of postnatal visit to low-risk primigravidae	Mean (mins.) Range (mins) SD	22 15-30 5.5

Midwives were asked to specify what they considered the most important elements of postnatal care and more than one element could be mentioned. Responses were the same in both phases and are shown in Table 6.1.8b. In both Phases of the study the provision of psychological support and ensuring physical and psychological wellbeing were mentioned most frequently. Providing advice and education to women about aspects of baby care were also seen as important.

Table 6.1.8b: Midwives' views of the most important elements of postnatal care (Phase 1&3)

Variable	No of times mentioned
Psychological support	7
Ensuring physical and psychological well-being	5
Advice / education	4
General baby care	2
Feeding support	1

A similar question asked what elements of a postnatal visit midwives found most time-consuming (Table 6.1.8c). Although the provision of advice and education to women about aspects of baby care were seen as important, this element of the visit was also most frequently mentioned as time-consuming. Other elements mentioned in response to this question included breastfeeding support and providing emotional support and listening to women.

Table 6.1.8c: Midwives' views of the most time-consuming elements of postnatal care (Phase 1&3)

Variable	No of times mentioned
Provision of education/advice	7
Breastfeeding support	5
Emotional support	5
Listening to women	3
Going over the birth experience	3

Midwives were also asked what factors were likely to make them visit a woman more frequently at home during the period of community support. (Table 6.1.8d). Midwives in both phases of the study said that where women needed physical, emotional or breastfeeding support they were more likely to

make extra visits. Other factors mentioned included young or inexperienced mothers or where there were poor family circumstances including a lack of social support.

Table 6.1.8d: Midwives' views of the factors which make them more likely to visit women postnatally (Phase 1&3)

Variable	No of times mentioned
Physical and emotional support to woman	10
Breastfeeding support	8
Young and/or inexperienced mothers	5
Maternal or neonatal history	5
Poor family circumstances / support	4

A further question asked midwives what factors influenced their decision to stop visiting women postnatally (Table 6.1.8e). The most commonly mentioned factors included a well mother and baby and a coping and confident mother. Less frequently mentioned factors included when the baby's cord was off and maternal choice.

Table 6.1.8e: Midwives' views of the factors which influence the decision to stop visiting postnatally (Phase 1&3)

Variable	No of times mentioned
Well mother and baby	14
Coping and confident mother	7
Feeding established	7
Cord off	4
Maternal choice	3

6.1.9 Midwives current job satisfaction

The majority of midwives in both phases of the study (n=11(8)) rated their job satisfaction as high or very high; the remainder rated their job satisfaction as medium. Although levels of job satisfaction were high, midwives were asked what would improve their levels of job satisfaction; many responded that more flexible working hours would be helpful. Three midwives said that they would like to improve continuity of care by providing more antenatal clinics in the community. Midwives also commented that they would like more input into intranatal and hospital postnatal care. One midwife said that although she

had a reasonable level of job satisfaction she needed a more varied workload. The majority identified co-operation, increased autonomy and better liaison with General Practitioners as issues that could improve job satisfaction. Three midwives highlighted that the reduction or abolition of 'on call' would improve continuity of care, as 'on call' commitments influenced their job satisfaction and interfered with continuity of care.

A series of Likert style statements were used to elicit midwives satisfaction with, and views of, the community postnatal care they provided to women and identified their perceptions of what postnatal women actually want. As previously explained in Chapter Four, the Chi squared test was not valid using such small numbers, so instead the Mann-Whitney U test was carried out. As the numbers of midwives were so small, any statistical interpretation of the results should be viewed with caution.

Although midwives said that they were satisfied with their job and the postnatal care they gave to women and their families, there was a subtle shift in job satisfaction between Phases 1 and 3. Although not statistically significant, midwives in Phase 3 were less likely to agree that they had plenty opportunities to develop their practice (p=0.1ns) and were more likely to be unhappy with their present working pattern and hours (p=0.5ns) (Table 6.1.9a). It was unclear whether the introduction of the new template had influenced this in any way.

Table: 6.1.9a Community Midwives current job satisfaction

Statement	Strongly agree/ Agree		Uncertain		Strongly disagree/ Disagree		Statistic al Test
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
I enjoy my job	16	13	0	2	0	0	p=0.7ns
My job is stressful	15	14	1	0	0	1	p=0.6ns
I have plenty opportunities to develop my practice	12	7	1	1	3	7	p=0.1ns
I am happy with my present working pattern and hours	11	8	1	1	4	6	p=0.5ns

An essential element in the job satisfaction and the subsequent care delivery of midwives is the opportunity to develop and advance clinically and professionally. The majority of midwives disagreed or were unsure whether postnatal care should continue to six weeks yet agreed that midwives should carry out the six-week postnatal check on low risk women (Table 6.1.9b).

Table 6.1.9b: What midwives should do postnatally

Statement	Strongly agree/agree		Uncertain		Strongly disagree/ disagree		Statistical test
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
Postnatal care by midwives should continue until the baby is six weeks old.	5	3	3	6	8	6	p=1.0ns
Midwives should carry out the six week postnatal check on low risk women	11	10	1	2	4	3	p=0.9ns

The study examined midwives perceptions of issues related to the provision of postnatal care and found that they varied in their perceptions of what women thought about postnatal care. Though not statistically significant there was a shift in attitudes between phases 1 and 3. A higher proportion of midwives in

phase 1 agreed or strongly agreed with the statement *"Some women do not want the midwife to visit them postnatally."* (Table 6.1.9c).

Table 6.1.9c: Midwives perceptions of what women want

Statement	**Strongly agree/agree**		**Uncertain**		**Strongly disagree/ disagree**		**Statistical Test**
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
Some women do not want the midwife to visit them postnatally	11	7	0	1	5	7	p=0.2ns
Many women find midwives visits threatening	6	2	0		10	13	p=0.3ns

Continuity of care was recognised by the majority of midwives as being important to the care they deliver and to women. Midwives comments reflected concern about continuity of care and conflicting advice:

> *"One of the problems with care is advice given by midwives is inconsistent. There appears to be some midwives who are more up to date with current practice and research than others. Therefore women are given conflicting advice, therefore continuity of care is good but continuity of advice is bad"*

Pragmatic suggestions about delivery of care were made in order to enhance continuity of care:

> *"As a whole we provide good postnatal care. I would like to be post coded therefore the community staff could deliver p.n. care to their patients, 'on call' could be organised a little better. Therefore a better system should be worked out through the team. Could be more General Practitioner-surgery midwives clinics"*

Most of the midwives agreed or strongly agreed that the postnatal woman should know the midwife who is visiting her. The majority of midwives said that they tried to meet women antenatally and agreed that continuity of care had improved in the past three years (Table 6.1.9d).

Table 6.1.9d: Continuity of care

Statement	Strongly agree/ Agree		Uncertain		Strongly disagree /disagree		Statistical test
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
I try to meet those women who I will visit postnatally/antenatally	16	14	0	0	0	1	p=0.4ns
Continuity of care for women has not improved much over the last 3 yrs.	2	3	1	0	13	13	p=0.8 ns

Views about postnatal care varied amongst midwives, many said that they would like to spend more time talking to postnatal women, yet disagreed with the statement 'I am not able to devote enough time to postnatal women and their babies' (Table 6.1.9e).

Table 6.1.9e: Midwives on postnatal care

Statement	Strongly agree/ Agree		Uncertain		Strongly disagree/ Disagree		Statistical test
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
I am not able to devote enough time to postnatal women and their babies	5	1	0	1	10	13	p=0.1ns
Midwives do not place enough emphasis on postnatal visits	1	1	1	1	14	13	p=0.7ns
Midwives devote too much time to the delivery of community postnatal care	1	1	1	1	14	13	p=0.7ns
Women do not get enough support from midwives in the postnatal period	2	2	2	0	12	13	P=0.9ns
If I had the time I would visit some postnatal women more often	8	7	0	1	8	7	P=0.8ns
I would like to spend more time talking to my postnatal women	11	9	0	0	5	6	p=0.3ns

Conflicting views emerged over the duration of hospital postnatal stay. In both Phases of the study the majority of midwives disagreed with the statement 'women are usually discharged from hospital too early after delivery'.

Table 6.1.9f: Postnatal hospital discharge

Statement	Strongly agree/agree		Uncertain		Strongly disagree/d.		Statistical Test
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
Low risk postnatal women spend too long in hospital	5	7	1	1	10	7	p=0.5ns
Women are usually discharged from hospital too early after delivery	3	1	1	0	12	14	p=0.8ns
10 days is too early to discharge women from the midwives care	5	7	2	1	9	6	p=0.7ns
A lot of women are not prepared for coming home from hospital with a baby	14	12	0	0	2	3	p=0.8ns

Over one third of the midwives agreed that ten days was too early to be discharged from the community midwife. In both Phases of the study the majority of midwives agreed or strongly agreed that many women are not prepared for coming home from hospital with their baby (Table 6.1.9f).

6.1.10 Organisation of care

Concern exists about the changing role and function of postnatal care within the greater organisation of the maternity services. On the whole midwives seemed happy with the existing organisation of maternity care. Midwives in Phase one were more likely to identify a need to alter the organisation of care delivered by the community midwives. However at the same time midwives appeared quite happy with the existing organisation of maternity care in the Trust. Most midwives felt that they spent too much time on routine clerical duties, such as filling in forms and writing case reports (Table 6.1.10).

Table 6.1.10: Midwives on organisation of care

Statement	Strongly agree/ Agree		Uncertain		Strongly disagree/ Disagree		Statistical test
	Phase 1	Phase 3	Phase 1	Phase 3	Phase 1	Phase 3	Mann Whitney
There is a need to alter the organisation of care delivered by midwives in the community	7	3	2	5	6	7	p=0.6ns
I spend too much time on clerical duties	11	9	0	1	5	5	p=0.3ns
The existing organisation of maternity care in my Trust is satisfactory.	9	10	4	1	3	4	p=0.9ns

In the section for free comments some midwives stressed that they felt they were constantly having to adapt and change in order to enhance the care they offer to postnatal women and to reflect the needs and demands of the service:

> *"We have learned to adapt and be flexible in most situations with the advent of one review after another. The women we care for still identify us as their midwife"*

Midwives commented that management and organisation of care was influenced by other factors:

> *"Since 1990, due to the pressures of understaffing at that time, I have, with colleagues been practising individualised patterns of care which also allowed for continuity of carer, less visits for mums and more visits for those with problems. I believe this has worked well and has not to my knowledge undermined the service given by community midwives but has enhanced it"*

6.1.11Collaborative working

Most midwives in both Phases agreed that better collaboration between themselves, General Practitioners and Obstetricians would improve the delivery of maternity care (Table 6.1.11). Midwives agreed that the midwife is the professional best placed to care for postnatal women and their babies. Interestingly, only a minority said that the General Practitioner should be more involved in the delivery of maternity care.

Table 6.1.11: Interdisciplinary teamwork

Statement	Strongly agree/ Agree		Uncertain		Strongly disagree/ Disagree		Statistical Test
	Phase 1	*Phase 3*	*Phase 1*	*Phase 3*	*Phase 1*	*Phase 3*	*Mann Whitney*
Better collaborative working between midwives, obstetricians and General Practitioners would improve the delivery of	14	13	0	0	2	2	p=0.4ns
General practitioners should be more involved in the delivery of maternity care	4	2	0	1	12	11	p=0.9ns
The midwife is the professional best placed to care for postnatal women and their babies	15	15	0	0	1	0	p=0.5ns

6.1.12 Content of postnatal visits

It was unclear from the data how much time was devoted to each task or whether tasks and assessments were carried out simultaneously. For example, the midwife might be assessing the emotional well-being of the mother while watching her feed the baby. Furthermore although midwives were asked to routinely record the duration of the postnatal visit, review of casenote data highlighted that this never occurred. Midwives argued that it would be too difficult to take note of the duration of postnatal visits.

As discussed in Chapter Four, when using such small numbers to compare outcomes, tests such as the X^2 test may not be valid. This was the case when a comparison between the content of a postnatal visit in Phase 1 and Phase 3 was made. It was not possible to collapse the information into two columns so that a Fishers Exact Test could be carried out. As grouping of categories to make 2x2 tables was not appropriate and there was no other test that could be done, the pattern of results is described in table format without significance testing. The tables demonstrate that there were no any substantial differences between Phases 1 and 3.

Table 6.1.12a: Postnatal visit (maternal assessment/ support)

Assessment	Phase 1				Phase 3			
Visits	All visit	1st visit	½ visits	Never	Every visit	1st visit	½ visits	Never
Parentcraft education	8	5	2	1	8	2	4	1
Ask about baby	13	1	2		10	1	4	
Assess maternal well-being	15	1			14		1	
Provide psychological support	12		4		12		3	
Assess psychological condition of mother	15	1			13	2		
Assess domestic situation	11	4	1		8	2	3	2

The routine for physical examination of mother and baby varied from midwife to midwife, 'routine' observations such as temperature and pulse tended to be carried out at every, or half the visits whilst blood pressure was more likely to be carried out once or not at all. Examinations of breasts, abdomen, perineum and lochia were likely to be carried out at every, or half the visits. There was no difference in the pattern of investigations between Phases 1 and 3 (Table 6.1.12b). One interesting observation was that 33% of midwives (n=5) in both phases of the study said that they take a maternal swab on at least half the postnatal visits.

Table 6.1.12b: Content of postnatal visit (maternal investigations)

Assessment	Phase 1				Phase 3			
	All visit	1st visit	½ visits	Never	Every visit	1st visit	½ visits	Never
Take maternal BP		7	4	4	3	4		8
Take maternal temp	6	4	6		9		4	2
Take maternal pulse	5	5	6		4	7	4	
Examine Breasts	2	2	10	2	5	4	4	2
Examine Abdomen	13		3		11		3	
Examine legs	7	3	6		9	1	5	
Take maternal swab	1	2	4	6	3	2		10
Examine lochia	7	3	6		9	2	4	
Check perineum/stitches.	9		7		9	1	5	

The majority of midwives carried out a full examination of the baby and checked the cord, temperature and skin at each visit. Watching the baby feed (irrespective of feeding method) was considered important by the midwives and the majority of midwives did this at every or half the visits. Most midwives said that procedures such as taking swabs and blood from the baby were completed when required, however a quite a high number (n=5) of midwives in Phase 3 said that took blood from the baby on at least half the visits (Table 6.1.12c).

Table 6.1.12c: Content of postnatal visit (baby)

Assessment	Phase 1				Phase 3			
	All visit	1st visit	½ visits	Never	Every visit	1st visit	½ visits	Never
Check baby's bottom	10		6		7	3	5	
Examine cord	13	1	2		11	1	3	
Examine baby	11	5			11	2	2	
Take blood from baby		14	2		2	11	3	
Swab from baby			1	15			2	13
Take baby's temp	10	2	4		4	2	9	
Check baby skin	10	3	3		10	2	3	
Watch baby feeding	7	3	5	1	2	4	9	

6.2 New Template Of Postnatal Care

The questionnaire for both Phases of the study was similar, however the second questionnaire incorporated three extra questions. These questions addressed the impact of the new template of postnatal visiting.

Midwives were asked if the introduction of the new template of postnatal care affected their role as a community midwife. Most said that there was little difference although it did influence their confidence in decisions about when to visit. One midwife said:

'I now feel more confident to miss (visits) over longer periods'

When questioned the majority of midwives perceived that the duration of postnatal visits was longer and, in some instances, midwives said that the new template freed time for other aspects of the job.

Midwives in both Phases of the study were asked to identify which factors were likely to influence their decision to visit a woman more often. Midwives identified psychological support, young/inexperienced mothers, feeding support, maternal /neonatal illness and family circumstances as factors indicating that the woman should be visited more often. The Phase three questionnaire did not include a question asking midwives to identify specific reasons for carrying out more than three visits on low risk women. However, following the introduction of the new template all community midwives were asked to cite the reasons for extra visits in the maternal casenotes. The retrospective review of casenotes notes was used to identify reasons for extra postnatal visits. In some instances more than one reason was identified. In most of the cases it was likely to be one maternal and one neonatal reason. However in 25% (n=10) where breastfeeding support was cited another maternal reason was also cited.

On review of the casenotes it was apparent that that many midwives did not comply with the request to identify the rationale for extra visits. In these instances the researcher used the other information in the casenotes to identify the most likely reason for the extra visit. In order to ensure validity, a community midwife was asked to randomly pick a selection of casenotes which did not have the reason for an extra visit cited. The midwife identified what she perceived to be the most likely reason for the extra visit and this was compared with the researcher's explanation. In all cases the midwife's rationale for extra visits concurred with the one identified by the researcher.

The casenote review highlighted that 107 women in Phase 3 had more than three visits, of those, 51 women had more than four visits. In some instances more than one reason was cited, the most commonly cited reasons were:

- Breastfeeding support and related problems such as mastitis (n=40)
- Perineal problems (bruised perineum, episiotomy problems (n=10)
- Maternal infection (n=3)
- Heavy vaginal discharge/passing clots PV (n=6)
- Maternal support (n=11).
- Maternal request (n=14)
- Telephone request (n=7)

Neonatal reasons contributed to a lesser extent to the reasons for extra visits. Neonatal jaundice was the major neonatal reasons for extra visits (n=27). In seven instances the midwives cited the cord on as the reason for the extra visit and a further four cited infant feeding problems.

6.2.1 Telephone helpline

The telephone helpline was introduced in Phase 3 of the study, although many women were given contact numbers (which may have been an answer phone) in Phase 1. Midwives were asked about the value of a twenty-four hour telephone helpline and had differing views about its value. The majority of midwives (n=10) said access to the telephone helpline did not reduce the need for postnatal visits and some said that it actually necessitated a visit, thus making extra work for midwives. The justification for midwifery visits following a telephone call was not investigated although the decision whether or not to visit may be a reflection of the midwife's ability to assess the situation over the phone.

6.3 Part 2: Results Of Evaluation Of A Template For The Provision Of Woman Centred Postnatal Care

This part of the chapter presents the findings of the study to examine women's perception of postnatal care provision before and after the introduction of a new model of postnatal care within a university teaching hospital in the West of Scotland. The aims, objectives and methodology were discussed in Chapter Four and this part of the chapter will present the findings of the before (Phase 1) and after (Phase 3) study. It will conclude by presenting a comparison of both. The specific objectives of this element of the study were to:

- Evaluate the current model of postnatal care provision in terms of clinical outcomes (maternal and neonatal), and maternal satisfaction;
- Evaluate the new model of postnatal care in terms of clinical outcomes (maternal and neonatal), and maternal satisfaction;
- Compare the outcomes of both models.

6.3.1 Evaluation of the current pattern of postnatal care provision

This part of the study reviewed and described the current pattern of postnatal care provision in terms of clinical outcomes (maternal and neonatal) and maternal satisfaction. Data on clinical outcomes was gathered through a retrospective review of records. These records included maternity case record, discharge register and woman-held notes. Information included demographic details; information about the pregnancy, labour and delivery; postnatal care of mother and baby including the method of feeding, number of midwife visits, number of wasted visits, outcomes of the visits and complications. The retrospective review of the casenotes was carried out manually by the researcher. The information obtained from this supported data obtained from the questionnaires while also supplementing information not obtainable from the questionnaires. Examples of supplementary information included:

Reasons for each postnatal visit;

- Wellbeing of mother and baby;
- Detailed information about care in labour, the postnatal ward and support since discharge;
- Information about the number of midwives who visited each woman.

Crucially the retrospective review of casenotes provided an added insight into postnatal care by the midwife and was valuable in identifying reasons for extra visits in Phase 3. The original intention of the review of casenotes was to record the duration of each postnatal visit, however midwives do not routinely record a duration for the visit. Midwives argued that noting the duration of

each visit would be a cumbersome and pointless addition to their workload. Nonetheless midwives in Phase 3 were asked to record the duration of each postnatal visit whenever possible – however this did not take place. Hence information about duration of visits is subjective (based on averages supplied by midwives and women) and general in nature. Two things hindered the review of casenotes;

1 Some of the casenotes were missing in spite of extensive searches
2 In many instances the nature and quality of the written documentation in the casenotes was poor and sometimes confusing.

Postal questionnaires were sent to women three weeks after delivery to assess maternal satisfaction, follow up letters were sent to non-respondents three weeks after the initial letter (appendix XIV).

6.3.2 Presentation of findings

The retrospective record review was completed for all women, however, as previously stated some of the hand-held notes were missing. Data lost from this source-included information about the content of each visit, the number of midwives who visited and whether any complications or problems were experienced by the mother or baby while the midwife was still visiting. Other information which was routinely obtained from the hand-held notes, such as the number of midwife visits, day of discharge from the midwife and method of feeding on discharge from the midwife, was obtained from the community record register. The final component of the postal questionnaire invited women to comment on any aspects of their postnatal care. Over one third of women added comments about some aspects of the care they received.

6.3.3 Recruitment to the study

Recruitment for the main study commenced in May 1997 and was completed in August 1997. Data collection ended in November 1997. All information was keyed into a database on SPSS for Windows and the same package was used to analyse the results. As explained in Chapter 4, recruitment was carried out by midwives working on the low dependency postnatal ward. For ease of

administration and to speed up recruitment to the study, midwives agreed that all women who fulfilled the criteria (which was likely to be the majority of women on this ward) would be asked to participate in the study on the day of discharge from the postnatal ward. It was intended that recruitment of women would form part of the discharge procedure for the duration of the study.

In spite of this, recruitment to the study was much slower than anticipated. The main reason for this seemed to be lack of midwife compliance, possibly related to changes in ward staff, workload and the introduction of twelve-hour shifts. The consensus of opinion amongst midwives themselves was that the introduction of 12 hour shifts reduced continuity of care and made it less likely for midwives to remember to include recruitment to the study as part of their discharge routine. Midwives reported that over 99% of women who were asked to participate in the study agreed to do so. Midwives said that the main reasons for women not agreeing to participate in the study were lack of time and the fact that some women were not returning to their home address for some weeks after the birth of the baby.

6.3.4 Non respondents

As previously stated women were recruited to the study in the postnatal ward. In order to compare respondents with non-respondents, postcodes and associated Cartairs neighbourhood type were compared. This demonstrated that there was no difference between the neighbourhood types of respondents and non-respondents. Caution should be expressed about the interpretation of this data, as the neighbourhood type index may be a bit out of date as it is based on the 1991 census. There were no statistical differences between the characteristics of respondents and non-respondents for parity ($X^2 = 236$, p = 0.627 ns), mode of delivery ($X^2 = 974$, p= 0.324 ns) and feeding method (X^2 1.585, p=0.208 ns). Women who responded to the questionnaire were older than non-respondents (t=3.485, p=0.001), with the average age of respondents 30 years versus 26.8 years for non-respondents.

6.3.5 *Phase 1: Evaluation of the original model of postnatal care provision*

A total of 208 women were recruited to the study. The response rate to the postal questionnaire following one follow-up letter was over 74%.

6.3.6 *Demographic details*

The demographic characteristics of all women recruited in Phase 1 are shown in Table 6.3.6.

Table 6.3.6: Demographic characteristics

Characteristics		**Phase 1 n=154**
Parity	Primigravidae	57 (37%)
	Multigravidae	97 (63%)
Marital status	Single	10 (6.5%)
	Married/partner	137 (89%)
	Missing	7 (4.5%)
Mode of Delivery	SVD	141 (91.6%)
	Instrumental	12 (7.8%)
	Missing	1 (0.6%)
Maternal Age	Mean (years)	30
	Range	17 - 42
	Median	30
Method of feeding in postnatal ward	Breast	82 (53.2%)
	Bottle	67 (43.5%)
	Missing	5 (3.2%)

6.3.7 *Length of stay in hospital*

The mean length of stay in the postnatal ward was 3.02 days (SD 1.1 Range 1-6 days). Two factors, parity and method of feeding, were likely to influence when the woman was likely to be discharged from the postnatal ward. Multigravidae, irrespective of feeding method were more likely to go home from hospital earlier than primigravidae (X^2=22.256 df=1, p<0.0005) (See Table 6.3.7a).

Table 6.3.7a: Discharge day by parity (n=154)

Day of discharge	**Primigravidae**	**Multigravidae**	**Total**
< or = 3	25 (43.9)	77 (79.4)	102 (66.2%)
> or = 4	32 (56.1%)	20 (20.6)	52 (33.8)
Total	57 (100%)	97 (100%)	154 (100%)
Statistical Test = X^2 = 20.256, df = 1, p < 0.0005			

Table (6.3.7b) shows that women who were bottle-feeding were more likely to be discharged from hospital earlier than those who were breastfeeding.

Table 6.3.7b: Day of discharge by feeding method (n-154)

Day of Discharge from Hospital	Breast Feeding	Bottle Feeding	Total
< or = 3	42 (51.2%)	57 (85%)	99 (64.2%)
> or = 4	40 (48.8%)	10 (15%)	50 (32.5%)
Missing			5 (3.3%)
Total	82 (100%)	67 (100%)	154 (100%)
Statistical Test : X^2=20.146, df = 2, p < 0.0005			

6.3.8 Discharge and community visit

Table 6.3.8 shows the mean length of stay in hospital for postnatal women. The average number of midwives who visited in the community was two, and most women were discharged from the care of their community midwife by day eleven.

Table 6.3.8: Discharge and community visit details

Variable		Phase 1 N=154
Day of discharge from hospital	Mean Range SD	3 1-6 1.3
Day of discharge from community midwife	Mean Range SD	11.1 5-13 1.25
Number of community midwife visits	Mean Range SD	4.3 3-6 0.93
Number of midwives who visited	Mean Range SD	2.0 1-3 0.7
Number of wasted visits	Total	15

6.3.9 Feeding

A similar proportion of both primigravidae and multigravidae breastfed whilst in the postnatal ward (X^2=0.789, df = 1, p < 0.674ns). In order to establish how long breastfeeding continued, women were asked questions about feeding

methods at specific times postnatally. By the time of discharge from hospital, six women had introduced some bottle feeds but were still putting the baby to the breast. For the purpose of analysis these women are described as breastfeeders. Data from the 154 women who completed the postal questionnaire established that ninety respondents (58.6%) breastfed while in hospital. By the time of discharge from the community midwife, 92.2% (n=83) of women who initially breastfed were still breastfeeding. At the time of completion of the questionnaire four to five weeks postnatally, only 71% (n=64) of the original breastfeeders were still doing so. This number includes eight women who were combining breast and bottle feeding.

Women were asked why they chose their particular method of feeding. Most women who elected to breastfeed felt it was best for the baby. Those who chose to bottle feed identified a variety of reasons for their choice, many said that it settled the baby better and it enabled all the family to help feeding the baby.

Table 6.3.9: Method of feeding in hospital and on completion of the questionnaire (4/52 postnatally)

Method of Feeding N=151	**In hospital**	**4 weeks postnatally**
Breast	91 (59%)	64 (41.5%)
Bottle	63 (41%)	87 (56.5%)

Table 6.3.9a shows that a significant number of women n=27 (17%) had changed from breast to bottle feeding since discharge from the postnatal ward. At the time of completion of the questionnaire at four weeks, 30% of women who were breastfeeding on discharge from hospital were no longer doing so. The questionnaire asked women why they had changed their method of feeding since the birth of the baby. In some instances women cited more than one reason for discontinuing. Reasons given for the change to bottle were sore breasts (n=14), demanding and tiring (n=10) and insufficient milk (n=9).

6.3.10 Postnatal visits

The mean number of community postnatal visits was 4.3. Table 6.3.10a gives a breakdown of the number of postnatal visits received by women in the sample.

Table 6.3.10a: Number of postnatal visits

Number of postnatal Visits	n=154
3	28 (18.4%)
4	71 (46.7%)
5	32 (21.1%)
6 and >	21 (13%)
Missing	2 (1.3%)

Women were asked about the postnatal visits. Most respondents (n=136, 88.3%) felt that the number of visits was just right although a small number (n=8, 5.2%) felt that they would have benefited from extra visits. Although 105 women (68.6%) were visited by more than one midwife, almost all of them (n=101, 94.3%) felt that this did not affect their care. All the women agreed that they felt able to ask the midwife questions and that the answers given were helpful.

Women were asked how decisions about postnatal visiting were made. Just over 71% of the respondents (n=110) said that decisions about when to visit were made jointly between the woman and the midwife. However, thirty-nine women (25%) said that the midwife made the decision. The remaining five women did not respond to this question. The majority of women (n=152, 99%) said that they knew the day the midwife was going to visit. But, sixty-six women (43%) said that they did not know when to expect a visit and of these, 23 (34.9%) said that they were unhappy with this arrangement.

The data was examined to see if women who were breastfeeding received more visits from the community midwife than those who were bottle-feeding (Table 6.3.10b). The table was collapsed to show the proportion of women who had three or fewer visits and those who had four or more visits. No statistically significant differences were found between the groups.

Table 6.3.10b: Number of visits according to feeding method (n=148)

Number of postnatal Visits	Breast	Bottle
< or =3	11(13.3%)	14 (21.2%)
4 and >	71(86.7%)	52(78.8%)
Total	82 (100%)	66(100%)
Statistical Test = X^2=1.604, df = 2, p < 0.447ns.		

The mean day of discharge from the community midwife was day eleven. Thirty one women (20%) were seen for twelve or thirteen days while a further 25 (16%) were seen fourteen days and beyond. Table (6.3.10c) shows that multigravidae were more likely to be discharged from the midwife at day ten.

Table 6.3.10c: Discharge day from midwife according to parity (n=145)

Discharge day	Primigravidae	Multigravidae
10	15 (27.8%)	41 (45%)
11 and >	39 (72.2%)	50 (55%)
Total	54 (100%)	91 (100%)
Statistical Test = X^2=4.267, df = 1, p < 0.039		

Table 6.3.10d shows that method of feeding did not effect the day of discharge from the midwife (X^2=1.120, df = 1, p < 0.290ns.)

Table 6.3.10d: Discharge day from midwife according to feeding method. (n=142)

Discharge day	Breastfeeding	Bottle feeding	
10	27 (34.2%)	27 (42.9%)	
11 and >	52 (65.8%)	36 (57.1%)	
Total	79(100%)	63 (100%)	
Statistical Test = X^2=1.120, df = 1, p < 0.290ns.			

Only one woman (0.6%) said that she made the decision about when the midwife should stop visiting postnatally. While 85 (55%) agreed that it was a joint decision and the remainder (n=66, 43%) said that the midwife alone made the decision.

6.3.11 Number of midwives to visit each woman at home

Given that continuity of care tends to be associated with having the same person to provide support, it was important to establish the number of community midwives who visited each woman at home and whether this in any way affected care. The average number of midwives who visited during a care episode was two (range 1-4). In the three cases where four midwives visited a woman, the fourth midwife was identified as a student midwife. The number of midwives who visited was recorded from the case notes by identifying each midwife's initials on the woman-held notes. However the accuracy of this data is questionable as 35 (16%) of the case notes were missing. Some of the missing information was obtained from the hospital record book, but details such as the number of midwives who actually visited each woman could not be obtained from this book. When this data was compared with women's responses to a question in the maternal questionnaire which asked about the number of midwives who visited at home, marked differences arose (Table 6.3.11). An explanation for the differences might be related to the number of hand-held notes which were missing.

Table 6.3.11: Number of midwives to visit each woman

Number of Midwives	Hand held note data (n=154)	Maternal Questionnaire (n=154)
One Midwife	29 (18.8%)	48 (31.2%)
Two Midwives	67 (43.5%)	77 (50%)
Three/more Midwives	32 (20.8%)	29 (18.8%)
Missing	26 (16.9%)	0

Women were asked whether seeing more than one midwife affected their care. Although six women said that they would have preferred to see the same midwife, only two of these said that seeing more than one midwife had adversely affected their care.

6.3.12 Other professional involvement at home postnatally

The woman-held notes were reviewed to see if other professional involvement was required at home postnatally. In 13 (8.5%) cases, another professional either visited the home or was contacted about the woman. In the majority of the cases, the other professional was the general practitioner. This figure does not include the routine courtesy call carried out by some General Practitioners postnatally. Women were asked if they received any visits from other professionals while the community midwife was still visiting, Eighty one (52.6%) said they received a courtesy visit from the General Practitioner and 43 (28%) had a routine visit from their health visitor. A further 111 women (72%) said that the health visitor called after the midwife stopped visiting.

6.3.13 Duration and content of postnatal visits

As the hand-held notes do not record the length of each visit, the questionnaire asked women to estimate the average length of each visit in minutes. There was considerable variation in women's responses. Thirty eight percent (n=57) said that each visit lasted approximately 15 minutes, a further 32% (n=49) said that it lasted 20 minutes and 25% (n=39) said it lasted longer (between 25 and 30 minutes). The majority of women (n= 145, 94%) said that the duration of the postnatal visits was just right and that they were satisfied with the visiting strategy.

Little is known about the factors which influence the timing and content of a postnatal visit. Information to help answer this question was obtained from the hand-held notes and questions included in the maternal questionnaire. Review of the hand-held notes suggested that in 60% of cases (n=100) the woman and baby had full head-to-toe examinations at every visit, yet the rationale for such examinations was not evident from the midwifery notes. The postnatal questionnaire asked respondents to identify whether specific tasks or investigations happened at every visit, half of the visits, one visit or not at all. The responses shown in Table 6.3.13a appear to demonstrate a discrepancy in the information obtained from the hand-held notes and the questionnaire data. In some instances women did not tick all the boxes

required and these missing variables account for discrepancies in some numbers.

Table 6.3.13a: Postnatal visit – maternal investigations (n=154)

Procedure (n=154)	Every visit	Half visits	Once	As Required
Examine Breasts	31(20%)	23 (15%)	34 (22.1%)	53 (34.4%)
Examine Abdomen	138 (90%)	7 (5%)	7 (4.5%)	1 (0.6%)
Check stitches	72 (47%)	10 (7%)	3 (1.9%)	28 (18.2%)
Examine Sanitary Pad	21 (14%)	10 (7%)	14 (9.1%)	92 (59.7%)
Examine legs	43 (28%)	25 (16%)	29 (18.8%)	48 (31.2%)
Take pulse	77 (50%)	22 (14.3%)	25 (16.2%)	26 (16.9%)
Take swab	6 (4%)	2 (1.3%)	8 (5.2%)	122 (79.2%)
Talk to you	143 (93%)	4 (2.6%)	1 (0.6%)	4 (2.6%)
Ask about yourself	148 (96%)	2 (1.3%)	2 (1.3%)	2 (1.3%)

The majority of women said that the midwife examined their baby at every visit. In most instances this included a full examination of the baby and the umbilical cord. In about two thirds of the cases the baby's temperature was taken (Table 6.3.13b).

Table 6.3.13b: Postnatal visit neonatal investigations (n=154)

Procedure	Every visit	Half visits	Once	As required
Examine your baby	133 (86%)	16 (11%)	2 (1%)	3 (2%)
Watch you feeding baby	18 (12%)	27 (18%)	27 (17%	72 (47%)
Look at cord	117 (76%)	29 (19%)	4 (3%)	3 (2%)
Take baby's temperature	96 (62%)	18 (12%)	17 (11%)	16 (10%)
Ask about baby	134 (87%)	3 (2%)	0	5 (3%)
Check baby's bottom	58 (38%)	35 (23%)	27 (18%)	28 (18%)
Check baby's skin	79 (51%)	31 (20%)	27 (18%)	9 (6%)
Take blood	8 (5%)	9 (6%)	119 (77%)	14 (9%)
Take a swab	7 (5%)	0	20 (13%)	112 (73%)

6.3.14 Knowing the community midwife

In the hospital where the study took place, community midwives tend to staff antenatal clinics at General Practitioner surgeries or Health Centres and hospital midwives staff hospital-based clinics. If a woman chooses to attend

the hospital clinic rather than a peripheral clinic/General Practitioner surgery, then she is less likely to meet the community midwife during the antenatal period. Almost 58% (n=89) of women had met the community midwife before she visited postnatally. This meeting usually took place in the General Practitioner surgery. Women who had not met the midwife prior to discharge home, said that they would have welcomed the opportunity to meet her. All women agreed that the community midwife had explained her role clearly to them.

6.3.15 Maternal health

Women were asked to compare their health now to before they were pregnant. In all, 53% of women (n=81) said that they felt about the same, 23% (n=36) said they felt better while the remainder (n= 37, 24%) said that they felt worse. The main reasons cited for feeling worse were tiredness and exhaustion. In some instances, women who said they were about the same or better, went on to write that they were feeling very tired and exhausted. Women were asked if they had experienced a variety of problems postnatally. The findings are shown in Table 6.3.15. The most common problems cited were engorged breasts and extreme tiredness. Only twenty women (13%) did not experience any problems postnatally and most of the women who experienced problems cited more than one problem.

Table 6.3.15: Maternal problems experienced postnatally

Maternal Problems	**Frequency (n=154)**
Engorged breasts	68 (43%)
Cracked nipples	25 (16%)
Backache	32 (21%)
Painful perineum	44 (28%)
Extreme tiredness	48 (32%)
Bladder	16 (10%)
Vaginal discharge	21 (13%)
Other	18 (12%)

Those women who cited "other" as a problem complained of haemorrhoids and mastitis as being the key problems.

6.3.16 Neonatal health

A concern of every new mother and father is the wellbeing of the baby. Much of the midwife's time in the postnatal period is considered to be spent educating parents about baby care and ensuring that the baby is well. Women were asked if the baby had experienced any problems since discharge from hospital. Only sixty one (39%) babies did not experience any problems following discharge. The most common difficulties are shown in Table 6.3.16.

Table 6.3.16: Neonatal problems since discharge

Neonatal Problems	n=154
Feeding problems	25(16%)
Infection	11(7%)
Sticky eyes	39(25%)
Jaundice	16(10%)
Other (rash, irritability)	27(17%)

When asked whether their baby was more demanding than anticipated, twenty women (13%) said yes, and a further forty eight women (31%) said that their baby was sometimes more demanding than anticipated. The majority of women (n=121, 79%) said that they received enough help to look after their baby, but many stated that more sleep would be appreciated. Women cited family and husband/partner as those more likely to offer support. Friends were rarely mentioned as sources of help and support to the woman. Some women expressed frustration. Even if they wanted help, it was not possible because they had no assistance available to them and they could not afford to pay someone to assist.

6.3.17 Discharge from hospital

Although this study was predominately about community based postnatal care, a question was included which addressed women's perceptions of their stay in hospital. In the majority of cases women felt that the decision to go home was made either by themselves (n=48, 31.2%) or in discussion or collaboration with the midwife (n=88, 57.1%). The majority of respondents (n=145, 94.2%)

were satisfied with the length of stay in hospital, the remainder said they were satisfied in some ways though not in others.

When questioned about length of stay in hospital, views varied from woman to woman. Only nineteen women (12.3%) agreed or strongly agreed with the statement that the 'next time I would like to go home from hospital sooner.' The majority of women said that they were not prepared for coming home from hospital. See Table (6.3.17)

Table 6.3.17: Discharge from hospital

Statement	Strongly Agree/Agree	Uncertain	Disagree/Strongly disagree	Missing
The Midwife helped the transition from hospital to home	107 (69.5%)	23 (14.9%)	19 (12.3%)	5 (3.2%)
I was not prepared for coming home from hospital with a baby	8 (5.2%)	8 (5.2%)	138 (89.6%)	
Next time I would like to go home from hospital sooner	19 (12.3%)	38 (24.7%)	94 (61%)	3 (1.9%)

6.3.18 Satisfaction with community postnatal care

A series of Likert style statements was developed in order to establish women's satisfaction with the community postnatal care they received. Analysis of the statements suggested a positive attitude towards community postnatal care (Table 6.3.18a).

Table 6.3.18a: Satisfaction with community postnatal care

Statement	Strongly agree/ Agree	Uncertain	Strongly disagree/ Disagree
I found the midwife's visits threatening	2 (1.3%)	2 (1.3%)	145 (97.4%)
I felt relaxed when the midwife visited	141 (91.7%)	5 (3.2%)	5 (3.2%)
I am very happy with the type of postnatal care I received	148 (96%)	1 (0.6%)	5 (3.2%)
I was happy to have the midwife visiting me in my own home	151 (92%)	1 (0.6%)	2 (1.2%)

The majority of women expressed positive views about the community midwives who visited and agreed that the midwife helped their transition to home following the birth. Women said that the midwife helped them feel in control and took time to talk to them. Almost half the respondents (n= 70, 45.6%) said that they were happy to allow the midwife to make all the decisions about their care (Table 6.3.18b).

Table 6.3.18b: Support of the midwife

Statement	Strongly agree/ Agree	Uncertain	Strongly disagree/ Disagree	Missing
I was happy to allow the midwife to make all the decisions regarding the care of myself and the baby	70 (45.5%)	30 (19.5%)	50 (32.5%)	4 (2.5%)
The midwife helped me feel more in control	115 (74.8%)	21 (13.7%)	16 (10.4%)	2 (1.2%)

6.3.19 Continuity of care

The majority of women agreed that every woman should know and have the same midwife visit during the care episode. Knowing the midwife who would visit at home was identified as important in some of the comments:

> *"All of the community midwives were very friendly and helpful as can be, but I feel that new mothers would benefit more if you met your community midwife while pregnant. By doing this you could build up a relationship and trust by the time you were due home."*

Table 6.3.19: Continuity of care

Statement	Strongly agree/ Agree	Uncertain	Strongly disagree / Disagree	Missing
I received conflicting advice from the midwives	25 (16%)	9 (6%)	117 (76%)	3 (2%)
It is important to have the same midwife visiting me at home	101 (66.4%)	20 (13%)	30 (20%)	1 (0.6%)
Every woman should meet their community midwife before the baby is born	120 (78%)	18 (12%)	15 (9.4%)	1(0.6%)

6.3.20Conflicting advice

Conflicting advice was singled out by some mothers as a cause of stress and anxiety. Sixteen percent of women (n=25) said that they had received conflicting advice from midwives. This was frequently mentioned in relation to breastfeeding, especially whilst in hospital:

> *"Difficulty with breastfeeding in hospital due to shift changes and conflicting advice...did not find the staff at night as helpful as during the day."*

6.3.21 Choice

Most respondents stated that they had confidence in the midwives who visited them, and felt that the midwife was genuinely interested in how they were feeling. Most women felt that their care was individualised and personal. Although it has been mooted that midwives' home visits can be stressful for some women, this was not found in the present study (Table 6.3.21a).

Table 6.3.21a: Individualised Care

Statement (n=154)	Strongly agree/ Agree	Uncertain	Strongly disagree / Disagree
The midwife took time to talk to me	149 (96.9%)	2 (1.2%)	3 (1.9%)
The midwife was interested in how I was feeling	143 (92.9%)	6 (3.9%)	5 (3.2%)
The midwife was more interested in my baby than me	7 (4.5%)	6 (3.9%)	141 (91.7%)
I thought the midwife would have been more of a help to me	6 (3.9%)	4 (2.5%)	144 (93.6%)
I had confidence in my community midwife	144 (93.6%)	7 (4.5%)	3 (1.9%)

Table 6.3.21b: Midwives visits

Statement	Strongly agree/ Agree	Uncertain	Strongly disagree / Disagree
The midwife's visits were too short	3 (2%)	11 (7%)	140 (91%)
I found the midwife's visits to be pointless	5 (3%)	2 (1%)	147 (96%)
Having a midwife visit me was a real lifeline	119 (77%)	21 (14%)	13 (9%)
I would have liked more midwife visits	14 (9%)	26 (17%)	114 (74%)
The midwife stopped visiting me too soon	7 (5%)	7 (5%)	140 (91%)

Women's responses to the Likert statements indicated that the majority were very happy with the support, timing and content of the postnatal visits they received at home and most women agreed that the midwife stopped visiting at just the right time.

Because the UK is one of the few countries that offers specific community midwifery support to women postnatally, the researcher was keen to establish whether these visits were valued by women. Table 6.3.21c shows women's responses to the questions about the place of postnatal visits. Most women were happy to have the midwife visit in their own home and seemed to prefer this option to visiting the midwife at the Health Centre or General Practitioner's surgery. In the majority of cases, women said that they looked forward to the midwife visiting them in their own homes.

Table 6.3.21c: Place of postnatal visits

Statement	Strongly agree Agree	Uncertain	Strongly disagree /Disagree
I looked forward to the midwife visiting me in my own home	128 (83.2%)	18 (12%)	7 (5%)
I was happy to have the midwife visiting me in my own home	151 (98.2%)	1 (0.6%)	1 (0.6%)
I would have preferred to visit the midwife at the Health Centre /General Practitioner surgery	2 (1%)	4 (2%)	147 (96%)

The community midwife was seen to facilitate the transition to home and midwives were identified as giving appropriate support to new mothers (Table 6.3.21d).

Table 6.3.21d: Preparation for Motherhood

Statement	Strongly agree/ Agree	Uncertain	Strongly disagree/ Disagree
The midwife didn't give me the support I needed	5 (3%)	2 (1%)	147 (96%)
Midwives do not provide enough care to new mothers at home	3 (2%)	6 (4%)	145 (94%)

6.4 Phase 2: Introduction Of The New Template Of Community Postnatal Care

The new model of care was introduced in October 1997. The model incorporated both the findings of Phase 1 of the study and the focus group study to establish women's expectations, perceptions and experiences of postnatal care. Midwifery workshops were also held to discuss options for the new template of community postnatal care.

The new template of postnatal care involved transfer of low-risk women from hospital to home within 48 hours of delivery. The postnatal visiting policy was to be based on individual need (maternal or neonatal), although each woman would have a minimum of three visits from the community midwives after discharge from hospital. The first visit was to take place within twenty hours of discharge, the second on day seven to complete the Guthrie test and a final discharge visit was scheduled for the tenth postnatal day before the woman was discharged to the care of the health visitor. Women were advised that they could telephone the hospital at any time for support and advice if they experienced any problems. Any postnatal visits by the midwife outwith the defined schedule were to be based on identified maternal or neonatal need. In order to manage the change successfully, a series of staff workshops were organised from within the hospital. The research midwife had no input into this process.

6.5 Phase 3: Evaluation Of The New Template Of Community Postnatal Care

The new model of care was allowed to run for four months before the final part of the study was conducted. This was to allow time for the new model to become embedded in practice. The same methodology and research instruments utilised in Phase 1 were used for this Phase of the study. A further consecutive sample of 205 women was recruited from the low dependency postnatal ward over a five month period between February and June 1998. As the findings of Phase 3 are similar to Phase 1 the results will be presented in a similar manner. As previously stated women were recruited to the study in the postnatal ward. Cartairs neighbourhood type were compared. This demonstrated that there was no difference between the neighbourhood types of respondents and non-respondents. A total of 205 women were recruited in the same manner as Phase 1 to the study. The retrospective record review was completed for all women (n=205). There was no statistical difference between the characteristics of respondents and non-respondents for age, parity, marital status, mode of delivery and method of feeding.

6.5.1 Findings

As found in Phase 1, 10.4% (n=26) of the woman-held notes were missing. The response rate to the postal questionnaire following one follow-up letter was 80% (n=160).

Table 6.5.1: Demographic characteristics

Characteristics		**Phase 3 n = 160**
Parity	Primigravidae Multigravidae	77 (44%) 89 (56%)
Marital status	Single married/partner missing	16 (10%) 142 (88.8%) 2 (1.2%)
Mode of Delivery	SVD Instrumental	152 (95%) 8 (5%)
Maternal Age	Mean (years) Range	29.9 17 - 43
Method of feeding in postnatal ward	Breast Bottle	93 (58.1%) 67 (41.9%)

6.5.2 *Length of stay in hospital*

The average day of discharge from hospital was 3.25. There was no statistical difference in discharge times between those who breast and bottle fed (See Table 6.5.2a). As in Phase 1, multigravidae were more likely to go home earlier than primigravidae Table 6.5.2b.

Table 6.5.2a: Day of discharge by parity

Day of discharge	**Primigravidae**	**Multigravidae**	**Total (n=160)**
< or = 3	24 (34.3%)	78 (86.7%)	102 (63.5%)
> or = 4	46 (65.7%)	12 (13.3%)	58 (36.5%)
Total	70 (100%)	90 (100%)	160 (100%)
Statistical Test = X^2= 45.108, df = 1, p < 0.0005			

The method of feeding did not affect day of discharge from hospital (Table 6.5.2b).

Table 6.5.2b: Day of discharge by feeding method

Day of discharge	**Breast Feeding**	**Bottle Feeding**	**Total**
<or = 3	58 (63%)	45 (66.2%)	103 (64.4%)
> or = 4	34 (37%)	23 (33.8%)	57(35.6%)
Total	92 (100%)	68 (100%)	160 (100%)
Statistical Test = X^2= 0.154, df = 1, p < 0.675ns)			

The mean length of stay in the postnatal ward was 3.25 days (SD=1.23 Range 1-6 days). The majority of women (n=154, 96%) were satisfied with their length of stay in hospital.

Table 6.5.2c: Discharge and community visit details

Variable		Phase 3 n=160
Day of discharge from hospital	Mean SD Range	3.25 1.23 1-6
Day of discharge from community midwife	Mean SD Range	11.54 2.46 1-23
Number of community midwife visits	Mean SD Range	4.2 1.17 2-9
Number of midwives who visited	Mean SD Range	2.08 0.76 1-4
Number of wasted visits	Total	12 visits

6.5.3 Feeding

Analysis of the data showed that a similar percentage of primigravidae and multigravidae breastfed (X^2=3.417, df = 1, p = 0.065 ns.). Six of the 88 (55%) women who elected to breastfeed had introduced some bottle feeds by the time of discharge from hospital.

Data from the 160 women who completed the questionnaire, established that 101 women (63.2%) breastfed while in hospital. By the time of discharge from the community midwife 85 (95%) of all questionnaire respondents who initially breastfed) were still breastfeeding. When the questionnaires were returned I don't understand, only seventy (69.3%) of the original breastfeeders were still doing so. Included in this number are twelve women (12%) who were combining breast and bottle feeding. The main reason cited for the change to bottle feeding was sore breasts (n=12). Less commonly cited reasons were; unsettled baby/not enough milk (n=8) and the demanding nature of breastfeeding (n=10). Table 6.5.3 shows the number of women who changed feeding method.

Table 6.5.3: Method of feeding in hospital and on completion of the questionnaire (4/52 postnatally) (n=160)

Method of Feeding	In hospital	4 weeks postnatally
Breast	101 (63.2%)	70 (43.8%)
Bottle	59 (36.8%)	90 (56.2%)
Total	160 (100%)	160 (100%)

6.5.4 Number of midwives to visit each woman at home

The average number of midwives to visit a woman during a care episode was two (range 1-4). As in Phase 1 the accuracy of this data is questionable. More women said that they were seen by the same midwife, than was evident from the data in the woman-held notes. Table 6.5.4 shows the number of midwives seen by women in the study.

Table 6.5.4: Number of midwives to visit each woman

Number of Midwives	Casenote Data	Questionnaire
One midwife	31 (19%)	44 (27%)
Two midwives	71 (44%)	84 (53%)
Three or more midwives	40 (20%)	32 (20%)
Missing	18 (11%)	0
Total	160 (100%)	160 (100%)

Women were asked whether seeing more than one midwife affected their care. Although six women said that they would have preferred to see the same midwife, only two of these said that seeing more than one midwife had adversely affected her care.

6.5.5 Other professional involvement at home postnatally

In eight cases (5%), another professional either visited the home or was contacted by the midwife about the woman. In the majority of the cases the other professional was the General Practitioner. Over half the women (n= 84, 52%) said they had routine courtesy visits from the General Practitioner and 49 women (31%) had a routine visit from their health visitor while the community midwife was still visiting.

6.5.6 Postnatal visits

The mean number of community postnatal visits was 4.2 (range 3-9). Table 6.5.6a shows that one third (n=52, 33%) of the women who completed the questionnaire were visited three times by the community midwife, the remainder were seen more often.

Table 6.5.6a: Number of postnatal visits

Number of postnatal Visits	N =160
3 Visits	52(33%)
4 Visits	56(35%)
5 Visits	31(19%)
6 and more visits	20(12%)
Missing	1(0.6%)

The majority of women (n=145, 91%) felt that the number of postnatal visits was just right. Those who expressed dissatisfaction said that they would have benefited from extra visits. A high proportion of women (n=116, 72%) were visited by more than one midwife, but when asked, 100 (87%) said that this did not affect their care. All women said that they felt able to ask their midwife questions and those who did found the answers helpful. Women said that decisions about visits tended to be a joint decision between the woman and the midwife (n= 116, 72 %). A further forty (25%) said that the midwife alone made the decision to visit. Table 6.5.6b, shows that women who breastfed were more likely to receive four or more visits from the community midwife. The X^2 test was not valid as more than 20% of the cells had an expected count of less than five, therefore cells were collapsed in the same manner to Phase.

Table 6.5.6b: Number of visits according to feeding method on discharge home

Number of postnatal Visits	Breast	Bottle
3 visits	25 (27.2%)	27 (40.2%)
4 and more visits	67 (72.8%)	40 (59.8%)
Total	93 (100%)	67 (67%)
X^2= 3.196, df=1, p=0.074 ns		

On average midwives stopped visiting at day eleven, although thirty three, (21%) were seen to fourteen days and beyond. Decisions about when to stop visiting were mainly joint decisions (n=82). However, seventy-three women (46%) said that only the midwife made the decision.

Table 6.5.6c: Discharge day from midwife according to parity

Discharge day	Primigravidae	Multigravidae	Missing
10	29 (44.6%)	38 (43.2%)	
11 and >	36 (55.5%)	50 (56.8%)	
Total	65 (100%)	88 (100%)	2
Statistical Test = X^2=0.051, df = 1, p = 1.822 ns.			

Parity did not appear to influence the day of discharge from the midwife. (Table 6.5.6c) However, women who breastfed their babies were more likely to be visited for longer than those who bottle fed (X^2=8.038, df = 1, p = 0.005 ns) (Table 6.5.6d).

Table 6.5.6d: Discharge day from midwife according to feeding method

Discharge day	Breastfeeding	Bottlefeeding
10	32 (35.6 %)	37(58.7%)
11 and >	58 (64.4%)	26 (41.3%)
Total	90 (100%)	63 (100%)

Although 156 women (97%) of women said that they knew the day the midwife was going to visit, almost half (n=69, 43%) said that they did not know the approximate time of the visit. Twenty-three (33.3%) of these said that they were unhappy with this arrangement. The majority (n=150, 94 %) of women said that the midwife could not have done anything else to help. When asked to rate the postnatal care they received overall 144 (90%) women rated their care good or excellent.

6.5.7 *Duration and content of postnatal visits*

In keeping with Phase 1 there was considerable difference in women's perceptions about the average duration of the postnatal visit. Forty four percent (n=70) said that each visit lasted approximately 15 minutes, a further 32% (n=52) said that it lasted 20 minutes and 24% (n=38) said it lasted longer (between 25 and 30 minutes). The majority of women (n= 150, 95%) said that the duration of the postnatal visits was just right and that they were satisfied with the visiting strategy.

Women were asked what happened at the postnatal visit and if it happened at every visit, half the visits, one visit or not at all (Table 6.5.7a).

Table 6.5.7a: Postnatal visit – maternal investigations

Procedure	Every visit	Half visits	Once	As Required
Examine Breasts	32 (20%)	25 (16%)	30 (11%)	67 (42%)
Examine Abdomen	128 (81%)	18 (11%)	8 (5%)	3 (2%)
Check stitches	61 (38%)	16 (10%)	11 (7%)	18 (11%)
Examine Sanitary Pad	15 (9%)	11 (7%)	18 (11%)	99 (62%)
Examine legs	34 (21%)	28 (17%)	34 (21%)	57 (26%)
Take pulse	79 (49%)	30 (19%)	15 (9%)	31 (19%)
Take swab	5 (3%)	1 (0.6%)	5 (3%)	128 (80%)
Talk to you	155 (97%)	1 (0.6%)	2 (1%)	2 (1%)
Ask about yourself	152 (96%)	3 (2%)	3 (2%)	2 (1%)

The retrospective review of woman-held notes suggested that in over 50% of visits the woman and baby had full head-to-toe examinations, however this is less clear from the questionnaire data. The casenotes did not identify why examinations took place although it may be that these were part of the midwife's normal postnatal visiting routine.

The majority of women said that the midwife examined their babies at every visit. In most instances this consisted of a full examination of the baby (Table 6.5.7b).

Table 6.5.7b: Postnatal visit neonatal investigations

Procedure	Every visit	Half visits	Once	As required
Examine your baby	136 (85%)	16 (10%)	4 (2%)	4 (2%)
Watch you feeding baby	16 (10%)	38 (23%)	37 (23%)	63 (39%)
Look at cord	123 (77%)	24 (15%)	10 (6%)	1 (0.6%)
Take baby's temperature	90 (56%)	29 (18%)	14 (9%)	15 (9%)
Ask about baby	130 (81%)	8 (5%)	3 (2%)	2 (1%)
Check baby's bottom	56 (35%)	35 (21%)	27 (17%)	31 (19%)
Check baby's skin	87 (54%)	31 (19%)	16 (10%)	12 (7%)
Take blood	10 (6%)	11 (6%)	118 (74%)	17 (11%)
Take a swab	5 (3%)	2 (1%)	23 (14%)	119 (74%)

6.5.8 Knowing the community midwife

Of the women who had met the community midwife before (n=106, 66.3%) the majority (n=72) said they met her in the General Practitioner's surgery. Many women who had not met the midwife prior to discharge home said that they would have welcomed the opportunity to meet her. All women agreed that the community midwife had explained her role clearly to them, but some women said that although the community postnatal care they received was good, they would have preferred to have met the midwife beforehand, one woman commented:

> *"The care I received both before during and after the birth was more than adequate. I did not know two of the midwives who visited me at home. I would have preferred it to be those who I had met antenatally at check-ups although I think it was due to holidays"*

6.5.9 Maternal health

Women were asked to tick appropriate boxes if they experienced problems postnatally. They could tick as many boxes as appropriate. The most common problems cited were engorged breasts and extreme tiredness. Only a small minority of women (n=12, 7%) did not experience any problems postnatally and most of the women who experienced problems cited more than one problem (See Table 6.5.9). Over one quarter of respondents (n= 43, 27%) said that they felt worse or much worse now than before they were pregnant.

Table 6.5.9: Maternal Problems Experienced Postnatally (n=160)

Problem	Phase 3
Engorged breasts	89 (55.%)
Cracked nipples	31 (20%)
Backache	45 (29%)
Painful perineum	37 (23%)
Extreme tiredness	68 (44%)
Bladder	21(14%)
Vaginal discharge	24 (16%)
Other	10 (6%)

6.5.10 Neonatal Health

Women identified problems that their babies had encountered, the most common being sticky eyes and jaundice (Table 6.5.10). Only forty two (26%) babies did not experience any problems postnatally.

Table 6.5.10: Neonatal health (n=160)

Neonatal Problems	Phase 3
Feeding problems	18 (11%)
Infection	14 (9%)
Sticky eyes	44 (28%)
Jaundice	36 (22%)
Other (colic, irritability)	16 (10%)

6.5.11 Discharge from hospital

The decision to go home was usually made either by the women themselves (n= 51, 32%) or in discussion with the midwife (n= 88, 55%). Most women agreed that the midwife helped the transition from hospital to home. Thirty three (21) % of the respondents said that next time they would prefer to go home from hospital sooner (See Table 6.5.11).

Table 6.5.11: Discharge from hospital

Statement	Strongly agree/agree	Uncertain	Disagree/Strongly Disagree
The Midwife helped the transition from hospital to home	100 (63%)	31 (19%)	22 (14%)
I was not prepared for coming home from hospital with a baby	4 (2%)	11 (7%)	142 (89%)
Next time I would like to go home from hospital sooner	33 (21%)	41 (25%)	80 (50%)

6.5.12 Maternal support

Twenty three women (14%) said that their babies were more demanding than anticipated and sixty-three (39%) said that the baby was sometimes more demanding than anticipated. The majority of women (n= 130, 81%) said that they got enough help to look after their babies, but many of these said that more sleep would be appreciated.

6.5.13 Telephone contact

Women in Phase 3 of the study were provided with a contact number which they were advised to call if they had any problems. One hundred and fifty two (95%) women said they were given this contact number. Of those who had been given the contact number thirty-five (22%) women said they used it. In the majority of cases (82%, n=31) women called the number for advice. When asked if the phone number was helpful that majority felt it was useful to have.

6.5.14 Feeding

The evaluation of the new template of postnatal care coincided with a drive in the hospital to gain 'Hospital Baby Friendly Status'. Women were aware of the "push" to breastfeed, however, some seemed to resent it. A typical comment to illustrate this was:

> *"I don't think the emotional pressure put on mums to breastfeed is necessary."*

Many women commented on the differences in support offered to women who were breastfeeding:

> *"In hospital I felt that if you weren't breastfeeding you were just left to your own devices. For Jacob's first feed the midwife gave*

me a bottle and walked away. She didn't ask if I had done it before or anything. Luckily I am a nursery nurse but she didn't know that!"

On discharge from hospital comments reflected a similar view:

"There was a definite difference in the care given to bottle feeders and breastfeeders. When breastfeeding, my visits were every day for an hour. When bottlefeeding, visits were more sporadic and only lasted 10 minutes. The change to bottle was stressful as "breast is best" is drummed into mums. This was compounded by midwives whose attitudes changed towards myself."

6.5.15 Satisfaction with community postnatal care

Most women had positive views of community postnatal care and 153(96%) respondents agreed or strongly agreed with the statement. "I am very happy with the type of postnatal care I received." Most women were happy to have the community midwife visit them in their own home (See Table 6.5.15a).

Table 6.5.15a: Satisfaction with community postnatal care

Statement	Strongly Agree/ Agree	Uncertain	Strongly Disagree / Disagree
I am very happy with the type of postnatal care I received	153 (96%)	4 (2%)	3 (2%)
I found the midwife's visits threatening	1 (0.6%)	3 (2%)	156 (97%)
I felt relaxed when the midwife visited.	141 (91%)	8 (5%)	5 (3%)
I was happy to have the midwife visiting me in my own home	158 (99%)	2 (1%)	0

Women agreed that the midwife helped them feel in control and that the midwife helped their transition to home following the birth (Table 6.5.15b). Over one third of the respondents said that they were happy to allow the midwife to make all the decisions about her care and that of her baby.

Table 6.5.15b: Support of the midwife

Statement	Strongly Agree/ Agree	Uncertain	Strongly Disagree/ Disagree
I was happy to allow the midwife to make all the decisions regarding the care of myself and the baby	65 (40%)	29 (18%)	62 (39%)
The midwife helped me feel more in control	116 (72%)	28 (17%)	16 (10%)

6.5.16 Continuity of care

Although two thirds of women were visited at home by more than one midwife, they said that this did not affect their care. The majority of women agreed that every woman should know and have the same midwife visit her during her care episode. A total of 16% of women said that they had received conflicting advice from the midwives (Table 6.5.16a).

Table 6.5.16a: Continuity of care

Statement	Strongly Agree/ Agree	Uncertain	Strongly Disagree/ Disagree
I received conflicting advice from the midwives	26 (16%)	13 (8%)	117 (73%)
It is important to have the same midwife visiting me at home	108 (67%)	18 (11%)	33 (20%)
Every woman should meet their community midwife before the baby is born	133 (83%)	15 (9%)	11 (7%)

A number of questions elicited women's feelings about the care given to them by the midwife (Table 6.5.16b).

Table 6.5.16b: Individualised care

Statement (n=160)	Strongly Agree/ Agree	Uncertain	Strongly Disagree/ Disagree
The midwife took time to talk to me	152 (95%)	5 (3.1%)	3 (1.9%)
The midwife was interested in how I was feeling	151 (94.4%)	4 (2.5%)	5 (3.1%)
The midwife was more interested in my baby than me	5 (3.1%)	8 (5%)	144 (90%)
I thought the midwife would have been more of a help to me	6 (3.8%)	10 (6.3%)	142 (88.8%)
I had confidence in my community midwife	140 (87.6%)	13 (8.1%)	5 (3.2%)

Most women were happy with the support, timing and content of the postnatal visits (Table 6.5.16c) and felt that the midwife stopped visiting at just the right time.

Table 6.5.16c: Midwives visits

Statement (n=160)	Strongly Agree/ Agree	Uncertain	Strongly Disagree/ Disagree
The midwife's visits were too short	7 (4%)	9 (6%)	142 (89%)
I found the midwife's visits to be pointless	1 (0.6%)	3 (2%)	154 (96%)
Having a midwife visit me was a real lifeline	124 (77%)	18 (11%)	17 (11%)
I would have liked more midwife visits	15 (9%)	33 (21%)	106 (68%)
The midwife stopped visiting me too soon	8 (5%)	5 (3%)	145 (92%)

Table 6.5.16d shows that women were happy to have the midwife visit her in her own home and seemed to prefer this option to visiting the midwife at the Health Centre or General Practitioner surgery. In the majority of instances the women said that they looked forward to the midwife visiting them in their own home.

Table 6.5.16d: Place of postnatal visits

Statement	Strongly Agree/ Agree	Uncertain	Strongly Disagree/ Disagree
I looked forward to the midwife visiting me in my own home	133(83%)	18(11%)	9(6%)
I would have preferred to visit the midwife at the Health Centre /General Practitioner surgery	2(1%)	12(7%)	143(89%)

The community midwife was seen as facilitating the transition to motherhood (Table 6.5.16b).

6.6 Comparison Of Both Models of Postnatal Care

This section combines the results of the before and after study. It compares and summarises the findings of both models of postnatal care. The presentation of the findings and statistical tests employed in this section are shown in a similar manner to those in sections 7.1 and 7.3.

6.6.1 Demographic details

The demographic characteristics of the women in the two groups were compared to this wasn't why you were comparing them.

Table 6.6.1: Demographic characteristics

Characteristics		Phase 1 n =154	Phase3 n = 160	Statistic Test	Significance
Parity	Primigravidae Multigravidae	57 (37%) 97 (63%)	77(44%) 89(56%)	$X^2 = 1.761$	p=0.181 ns
Marital status	Single Married/partner	17 (8%) 137 (66%)	16(8%) 141(69%)	$X^2 = 0.069$	p=0.739 ns
Mode of Delivery	SVD Instrumental Missing	141(91.6%) 12 (7.8%) 1 (.6%)	152(95%) 8 (5%)	$X^2 = 1..057$	p= 0.304 ns
Maternal Age	Mean (years) Range	30 17 - 42	29.9 17 - 43	T=0.209	p=0.959 ns
Method of feeding In postnatal ward	Breast Bottle Missing	82(53.2%) 67(43.5%) 5 (3.2%)	93(58.1%) 67(41.9%)	$X^2=1.438$	p= 0.487 ns

No statistical differences were found between groups for the following variables: age, parity, mode of delivery, marital status and method of feeding on postnatal ward (Table 6.6.1).

6.6.2 *Length of stay in hospital*

The introduction of the new template of postnatal care was intended to reduce the length of hospital postnatal stay, although not statistically significant the average length of stay in hospital was longer in Phase 3 (3.0 v 3.25: t= -1.707, p=0.089) (Table 6.6.4). Two factors were likely to influence the length of stay in hospital: parity and method of feeding. Multigravid women, irrespective of feeding method were more likely to go home from hospital earlier than primigravidae. In Phase 1 women who were bottle-feeding were more likely to be discharged from hospital earlier than those who were breastfeeding (see Table 6.3.7b), but in Phase 3 there was no statistical difference in discharge times between those who breast and bottle fed (Table 6.5.2b).

Women in both Phases of the study agreed that they were involved in the decision about when to go home from hospital and were satisfied with their length of stay in hospital. In spite of the negative comments about hospital care, especially in relation to parentcraft education, the majority of women disagreed with the statement that they were not prepared for coming home from hospital.

6.6.3 *Feeding*

The introduction of the new model of care had no impact on the initiation or duration of breastfeeding (Fisher's Exact Test, p=0.842). In both Phases of the study women cited '*breast is best for baby' as* the reason they chose to breastfeed. Those who bottle fed said that it was more convenient and it settled the baby better.

Table 6.6.3: Feeding in the postnatal ward by parity

Method of Feed in Postnatal Ward	Phase 1 n= 154	Phase 3 n=160	Test statistic Significance
Breast Feeding	91	93	X^2 0.030 p=0.862ns
Bottle Feeding	63	67	

A similar number of women in both Phases had changed from breast to bottle feeding by the time of completing the questionnaire. Thirty five respondents in Phase 1 and thirty seven in Phase 3 changed their method of feeding after their baby was born (Fisher's Exact Test $p < 1.000$). There was no difference in the average number of postnatal visits to breast and bottle feeders.

6.6.4 Community Postnatal care

The introduction of the new model of community postnatal care did not appear to influence community midwife visiting details. There was no difference in the average number of midwife visits or day of discharge from the community midwife (Table 6.6.4a).

Table 6.6.4a: Discharge and community visit details

		Phase 1	Phase 3	Test statistic Significance
Day of discharge from hospital	Mean SD	3 1-6	3.25 1.23	t = -1.707 p= 0.089ns
Day of discharge from community midwife	Mean SD	11.1 1.25	11.54 2.46	t= -1.775 p= 0.077ns
Number of community midwife visits	Mean SD	4.3 0.93	4.2 1.17	t= 1.664 p= 0.097 ns
Number of midwives who visited	Mean SD	2.06 0.73	2.08 0.76	t= .469 p= 0.640 ns
Number of wasted visit		15	12	

Part of the rationale for introducing a new model of community postnatal visiting was that women would be seen by the same midwife, thus increasing satisfaction and continuity of care. However, analysis of the findings suggests that there was no difference in the average number of midwives to visit each woman in her home. Furthermore the pattern for the number of midwives to visit each woman was similar in both phases of the study (Table 6.6.4b).

Table 6.6.4b: Number of midwives to visit each woman

	Phase 1 n=154	Phase 3 n=160
One Midwife	48(31%)	44(27%)
Two Midwives	77(50%)	84(53%)
Three/four midwives	29(19%0	32(20%)
Total	154 (100%)	160 (100%)

There was a perception that many community midwife visits were 'wasted' visits (i.e. midwife visits the woman's home but there is nobody in) and that introducing a planned model of care would help reduce this figure. In fact there were few wasted visits in this study and there was no statistical difference the number of wasted visits (t-test = 1.788, p=.075ns).

6.6.5 Postnatal visits

There was no difference in the mean number of postnatal visits in Phase 1 and Phase 3 (Table 6.6.4a)) although further analysis of the data highlighted a difference in the pattern of postnatal visits. Women in Phase 3 who had three visits were more likely to be seen by the same midwife (p=.005) but this was a small number (n=5 in Phase 1, n=16 in Phase 3).

Table 6.6.5: Number of postnatal visits

Number of visits	Phase 1 2 missing	Phase 3 1 missing	Total 3 missing
3 visits	28 (18%)	52 (32%)	80 (26%)
4 and more	124 (81%)	107 (67%)	231 (73%)
Range	3-6 visits	3-9 visits	
SD.	1.00	1.17	
Total	152 (99%)	159 (99%)	311 (99%)
Statistic test t-test =2.910 p= <0.004			

6.6.6 Timing of postnatal visits

In keeping with other findings in this study, the new model of care did not appear to impact on the timing and duration of postnatal visits. On average,

midwives stopped visiting at day eleven although women in Phase 3 were more likely to be visited by a midwife on or after the fourteenth day (p=<0.0005). Analysis of the data highlighted that 21 of the 29 women who were visited on or after the fourteenth day were breastfeeders. As the woman-held notes do not give an indication of length of each visit, the questionnaire asked for the average length of each visit in minutes. In both phases of the study the average length of a visit was 20 minutes and the majority of women (94%) said that this was just right. Women in both Phases were satisfied with the visiting strategy.

6.6.7 *Content of the postnatal visit*

Women were asked what happened at the postnatal visit, and if it happened at every visit, half the visits, one visit or not at all. There was no statistical difference between Phases 1 and 3 in the maternal (Table 6.6.7a) and neonatal (Table 6.6.7b) investigations carried out at every visit.

Table 6.6.7a:Postnatal visit – maternal investigations at every visit

Procedure carried out at every visit	Phase 1	Phase 3	Statistical test
Examine Breasts	31(20%)	32(20%)	X^2=1.14.2 Df=3, p=.703ns
Examine Abdomen	138(90%)	128(81%)	X^2=1.131 Df=3, p=.105ns
Check stitches	72(47%)	61(38%)	X^2=9.762 Df=3, p=.045
Examine Sanitary Pad	21(14%)	15(9%)	X^2=1.676 Df=3, p=.642ns
Examine legs	43(28%)	34(21%)	X^2=2.177 Df=3, p=.537ns
Take pulse	77(50%)	79(50%)	X^2=4.114 Df=3, p=.249ns
Take swab	6(4%)	5(3%)	Fisher's Exact test P=<0..59
Talk to you	143(93%)	155(97%)	Fisher's Exact test P=<0.495
Ask about yourself	148(96%)	152(95%)	Fisher's Exact test P=<1.000

The majority of women said that the midwife examined their baby at every visit, with, in most instances, a full examination of the baby including examination of the umbilical cord. (Table 6.6.7b)

Table 6.6.7b: Postnatal visit neonatal Investigations at every visit.

Procedure carried out at every visit	Phase 1	Phase 3	Statistical Test
Examine your baby	133(86%)	136(85%)	Fisher's Exact test p=<0.575ns
Watch you feeding baby	18(11%)	16(10%)	X^2 =3.810 df=3, p=.283ns
Look at cord	117(76%)	123(77%)	Fisher's Exact test p=<0.468
Take baby's temperature	96(62%)	90(56%)	X^2 =3.087 Df=3, p=.0.378ns
Ask about baby	134(87%)	130(81%)	Fisher's Exact test p=<1.000
Check baby's bottom	58(38%)	56(35%)	Fisher's Exact test p=<0.722
Check baby's skin	79(51%)	87(54%)	X^2 =4.273 Df=3, p=.233ns
Take blood	8(5%)	10(6%)	X^2 =0.559 Df=3, p=.0.897ns
Take a swab	7(4%)	5(3%)	Fisher's Exact test p=<1.000

6.6.8 Maternal health

When asked to compare their health now, there was no statistical difference between the groups in the numbers of women who said they felt worse postnatally (Table 6.6.8a).

Table 6.6.8a: Present health now compared with before the pregnancy

Present health compared with before pregnancy	Phase 1 n=154	Phase 3 n=158
About the same or better	117(76%)	115(72.8%)
Worse or much worse	37(24%)	43(27.2%)
X^2 =0.416 Df=1, p=.0.519ns		

Table 6.6.8b: Maternal problems experienced postnatally

	Phase 1 n=154	Phase 3 n=160	Test statistic Significance
Engorged breasts	68(42%)	89(55%)	$X^2 = 4.129$ p= 0.042
Cracked nipples	25(15%)	32(20%)	X^2 .749 p= 0.387 ns
Backache	32(20%)	46(29%	X^2= 2.670 p= 0.102 ns
Painful perineum	44(27%)	37(23%)	X^2= 1.216 p= 0.270 ns
Extreme tiredness	48(31%)	71(44%)	X^2= 5.815 p= 0.016
Bladder	16(10%)	23(14%)	X^2= 1.146 p=0.284 ns
Vaginal discharge	21(13%)	25(16%)	X^2= .248 p=0.618 ns
Other	18(11%)	10(6%)	X^2=5.562 p= 0.135 ns

More women in Phase 3 complained of engorged breasts and extreme tiredness (Table 6.6.8b). In order to establish the significance of these findings Bonferroni's test was used. This test carries out pairwise comparisons between the group means, but takes into account the number of tests (Puri, 1996). The findings highlight that the increase in women citing extreme tiredness and engorged breasts was not significant.

There was no statistical different in the number of women who did not experience any postnatal problems (X^2= 1.181 p=0.108ns). Twenty (13%) women in Phase 1 did not report any postnatal problems and twelve (7%) of women said they did not have any postnatal problems in Phase 3.

6.6.9 Neonatal health

More babies in Phase 3 became jaundiced and, using Bonferroni's test this finding was found to be significant. Of the 314 women who completed questionnaires in Phases 1 and 3, only one third (29%, n=91) said that their babies did not experience any problems after discharge from hospital. (Table 6.6.9).

Table 6.6.9: Neonatal problems experienced at home

Neonatal Problems	Phase 1 n=154	Phase 3 n=160	Test statistic Significance
Feeding problems	25(16%)	18(11%)	X^2=.1.649 p= 0.199 n.s
Infection	11(7%)	14(9%)	X^2=0.277 p= 0.599 n.s.
Sticky eyes	39(25%)	44(28%)	X^2=.191 p= 0.662 ns
Jaundice	16(10%)	36(22%)	X^2=8.329 p= 0.004
Other (rash, irritability/colic)	27(17%)	16(10%)	X^2=7.335 p= 0.062ns

6.6.10 Knowing the community midwife

The new model of postnatal care recommended that the women would know the midwife who visited her at home, 58% (n=89) in Phase 1 knew the midwife compared with 66.9% (n=107) in Phase 3 (X^2=2.312, df=1, p= 0.128). There was no statistical differences between the Phases in the number of women who were seen by one midwife although women in Phase 1 who received three visits were more likely to be seen by the same midwife than those in Phase 1.

6.6.11 Satisfaction with community postnatal care

Overall women were very happy with the community postnatal care they received. Analysis of the Likert statements highlighted similar findings in both Phases of the study. Women agreed that the midwife helped them feel in control, and found that the midwife took time to talk to them. Over one third of the respondents said that they were happy to allow the midwife to make all the decisions about their care and that of the baby. The respondents said that they had confidence in the midwives who visited them, and said that the midwife was genuinely interested in how they were feeling. The majority of women were very happy with the support, timing and content of the postnatal visits. Most women agreed that the midwife stopped visiting at just the right time. Sixteen percent of women in both Phases of the study said that they had received conflicting advice from the midwives. Over two thirds of women were visited at home by more than one midwife but most women said that this did not affect their care. The majority of women agreed that every woman should know and have the same midwife visit her during her care episode.

Women were happy to have the midwife visit her in their own home and seemed to prefer this option to visiting the midwife at the Health Centre or General Practitioner surgery. The community midwife was seen to facilitate the transition to home and midwives were identified as giving appropriate and sufficient support to new mothers.

6.6.12 Comments

Comments in both Phases of the study were remarkably similar. Analysis of Likert statements suggested a positive attitude towards community postnatal care. However, comments from some women expressed concern about postnatal care particularly hospital postnatal care, especially the lack of education and support given to first time mothers. A number of women expressed concern about the difference in support offered to breastfeeding women. Women placed particular emphasis on lack of support and parentcraft education by hospital midwives.

Comments were made that staff were very busy and women felt unable to approach them and ask for advice. Comments were made about the "busy-ness" of staff, with women suggesting that they were afraid to ask the midwife for help/support as she looked so busy:

> *"I found the ward midwife's attitude patronising and quite offensive. She had absolutely no respect for my views or opinions and she seemed to be of the view that as a midwife her wishes and demands were more important than mine. I have a three year old as well so I've done it all before. The ward midwife undermined my confidence at every turn."*

Conversely some women commented that hospital care was better than expected:

> *"All members of staff at the QMH were most helpful and nothing was a bother to them. The care I received could not have been better; also the advice I received could not have been better. The care after I left hospital was every bit as good."*

> *"I found my stay in hospital very pleasant and relaxing. I also received all the care and help I needed for myself and my baby in the hospital and at home. I will have no worries or queries if I decide to have another child in the Queen Mothers. I would like*

to thank all the staff and midwives for all their care and kindness."

One woman expressed the view that those who go home early should get added support whilst in hospital:

"In the current system when there is combined care between the hospital and community midwife, the number of visits by the midwife is probably quite adequate. But with more intensive care by the midwives, mothers who wanted to would be able to leave hospital quicker."

Women expressed concern about the limited information available about the transition to motherhood and the postnatal period:

"The midwife explained in detail about my breasts and I was given a vague idea of the length of time the stitches would take to heal. But nobody explained beforehand how painful and long the recovery period would be."

Women highlighted the importance of being able to talk to the midwife:

"I really appreciated having someone there to talk to and answer questions. Having a new baby is pretty terrifying and you often feel very inept. But because you are experiencing everything for the first time, I think it would have been extremely helpful for the midwife to go through the points of childcare with you. All babies are obviously different but there are tried and tested methods that work. How do you as a first time mum find them out without being shown?"

"In hospital there did not seem any room for dialogue with midwives. As a result a completely healthy baby ends up in a neonatal ward because they happen to know I carry Hep B Strep.- I felt really stupid."

Some women commented that it was the doctors who made decisions:

"In hospital you are at your most vulnerable, little explanation is given about possible problems. Doctors who visit infrequently make decisions and don't take time to explain their decisions and the nurses are left to cope with the outcome. We are both well but I was very frustrated by my postnatal care."

Some mutigravidae took the opportunity to highlight the support they got from the community midwife.

"I strongly feel that this being my second child, the community midwives were a blessing before and after the birth."

Conflicting advice was singled out by some mothers as a cause of stress and anxiety:

> *"However I was extremely unhappy with the care I received while in hospital. As a first time mum I was not helped enough and given conflicting advice on how to care for my baby. I was left to my own devices and being a young first time mum was very daunting."*

This chapter presented the findings of two related studies. Part one described the findings of the before and after study to establish midwives perceptions of the postnatal care they provided to women. Part two presented the findings of the before and after study to establish postnatal women's views about the community postnatal care they received. The next chapter (Chapter Seven) will discuss the findings of the study.

6.7 Summary of findings

Baseline data from Phase 1 of the study demonstrated that women were generally very satisfied with all elements of community postnatal care and this continued to be the case following introduction of the new template of postnatal care. The main findings of the study showed that there was no difference in clinical outcomes and maternal satisfaction between Phase 1 and Phase 3. Midwives did employ certain elements of the template and more women in Phase 3 had three postnatal visits, but the mean number of postnatal visits to each woman remained the same. The reason for this may be that midwives used the freed time from the reduction of visits to low risk women to give extra visits, or spend more time with those women who required them. Breastfeeding rates and duration of breastfeeding were similar in both phases, as were neonatal and maternal morbidity rates. Women in both Phases of the study were satisfied with the postnatal care they received, liked the community midwife visiting them in their own home, found her to be helpful, comforting, supportive and informative.

There was no difference in the mean the number of community midwives to visit each woman or day of discharge from the community midwife. The average postnatal stay was longer in Phase 3 although there appears to be no clear reason for this. Analysis of the data highlighted that there was a change

in the pattern of visits. More women in Phase 3 were seen three times and fewer were seen four times. The shift in visiting pattern was between three and four visits, suggesting that midwives were more selective about the visits they made to low risk women in Phase 3. More women in Phase Three reported extreme tiredness and engorged breasts, and there was a difference of 6% in mothers not reporting any postnatal problems, however as explained in the previous chapter these findings were not significant. In questioning why a comparison of Phases yielded these outcomes, cognisance should be taken of the complexities in measuring satisfaction combined with the variety of factors which impinge on maternity and particularly postnatal care provision.

Although the majority of women were happy with community postnatal care provision irrespective of Phase, the study highlighted that while midwives believe they are providing a quality service and meeting the needs of young mothers this is not always the case. An equally interesting outcome of this study was that certain elements of the template were not introduced. The main change in outcome related specifically to the change in the balance of women who were visited three or four times in Phases 1 and 3. Furthermore, although women said they were satisfied with their care, many went on to express concerns. This happened irrespective of Phase. As the thesis comprises of three individual but interconnected studies the discussion in Chapter Seven will integrate the findings, especially the findings presented in this chapter. As the findings of the focus group study were discussed in Chapter five, these will be referred to when relevant. The following chapter will discuss the findings and identify and describe the factors which may have impacted on the study outcome.

CHAPTER SEVEN

EVALUATION OF A TEMPLATE FOR THE PROVISION OF WOMAN CENTRED POSTNATAL CARE - DISCUSSION

The research question reflected on the nature, quality and outcomes of community postnatal care and asked whether the introduction of a new template of postnatal care would achieve the same outcomes and satisfaction as the existing model.

The new template of postnatal care was informed by the available evidence, midwives' views and the findings of the focus group study. The findings of the before and after study presented in previous chapters raised many issues about the management of change, the nature/potential of community postnatal care and the organisation, delivery and priorities of community midwifery care. It was hoped that by introducing a woman centred model of community postnatal care, a series of benefits would occur. The first phase of the study was intended to obtain baseline information and provide insight into possible models of care which could be introduced. The findings of Phase 1 highlighted that the majority of women were satisfied with their community postnatal care. The pattern of care did not change between the phases so, not surprisingly, there was no difference in outcomes or maternal satisfaction. Possibly the most perplexing element of this study centres on why the planned change in the service did not actually happen. In order to explain this, possible reasons including the management of change, the template itself, consumer and midwifery perspectives, will be discussed.

7.1 Management Of The Change

In questioning why there was no major change in outcomes and satisfaction, the way in which the change was managed must be addressed. Chapter Four explained the considerable groundwork which took place to ensure that change was managed effectively and efficiently. The foundation work for the planning and implementation of the change was carried out by the senior midwife in charge of community care and some community midwives.

In keeping with the principles of change management the community midwives were actively involved in planning the proposed changes. Although the increased responsibility associated with the introduction of new models of care can lead to enhanced confidence and professional satisfaction, it can also lead to stress (Hunt, 1997). In an attempt to combat this, the proposed change and its rationale were presented to the midwives in a non-threatening manner. A criticism of the change management process could have been the failure to include all midwives at every stage including the planning phase. Because the main focus of the change was community midwifery care, not enough attention was paid to the importance of getting the opinion of a wider circle of midwives who were likely to be directly or indirectly involved with the change. McCourt & Page (1996) stress the need to consult and communicate with all midwives involved with the delivery of maternity care, irrespective of whether they will be involved with the study/model of care or not. In this study failure to include all midwives in the planning stage may have adversely affected implementation and outcomes of the study. All midwives who worked in the Trust should have received the same standard of information about the study, thus increasing the chances of all elements of the template being implemented. In planning the change to postnatal care provision, community midwives completed a SWOT analysis (strengths, weaknesses opportunities and threats) of the proposal. This demonstrated the need to rationalise visits, but also raised concern that midwives should retain their autonomy in deciding when to visit. All community midwives were invited to become involved in early discussions and the development of the programme. Midwives were encouraged to participate actively in the planning stage of the new template.

The new template of care was informed by audit, available evidence and discussion. All midwives understood that the template was to be used in conjunction with their own professional judgement. The model of postnatal care had the full support of other health care professionals. In keeping with theories of change management the midwives went through stages of interpretation of the changes similar to those described by Isabella (1990) and

as identified in Chapter Three. The organisational culture for midwives working in the community differs from that for hospital based midwives. 'Champions' from the community, but not the wards, were identified to act as advocates for the change. Consequently, ward based midwives were not encouraged to support the proposed changes.

In spite of the groundwork with the community midwives, findings suggest that some elements of the change may have been inadequately discussed with the community midwives (for example the importance of continuity of carer and meeting the woman she will care for – antenatally).

Implicit in the new template of postnatal care was the belief that midwives involved had the appropriate skills to support it. All midwives were experienced and the majority were 'G' grade. Possibly because of this there was an acceptance that the midwives understood and supported the philosophy and rationale for change. It was acknowledged that midwives had the clinical skills to introduce the new template but little if any attention was paid to ensuring that midwives had the decision-making skills required to introduce the new model of care.

Midwives said that due to service demands some changes in how they organised and delivered care had already taken place. In Phase 1 of the study, midwives highlighted that their role had changed markedly over the previous eighteen months, but many expressed frustration that the changing roles and responsibilities were not acknowledged by the hospital management. This is a view supported by Barber (1998) who says that although the role of the midwife has changed radically the organisation, of which they are a part has not. Community midwives may on the one hand be expected to practise autonomously but on the other are answerable to medical staff and managers. Midwives said that they were recipients of what seemed like constant change over the previous decade and much of this was in response to government reports (SOHHD, 1993; DOH 1993) and the efforts of consumer and pressure groups (Sandall 1995). In keeping with the rest of the UK many community midwives are being asked, cajoled or forced to change the ways in which they

work (Hunt, 1997). However, although there have been many changes the cumulative impact of these does not appear to have been anticipated or considered by midwives or management. Some examples of recent changes which impacted directly and indirectly on community midwifery care without a subsequent increase in community midwifery staff are;

1 Early postnatal discharge from hospital.
2 Move to increase the number of women who are 'booked' in their own home or in the community by community midwives.
3 Increase in the amount of antenatal care carried out by community midwives.

The implementation of the new model of community postnatal care took place at a time when midwives were concerned about the future of the hospital. In spite of management efforts to quell fears, midwives continued to be concerned about job security. Because of senior midwife involvement, midwives may have perceived the study to be management driven even though all community midwives were encouraged to become involved in developing the template. This concern may have influenced how midwives implemented the template of care. Furthermore, midwives may have had concerns about the impact of reducing the number of postnatal visits. Burnout amongst midwives has been a topical issue (Sandall 1997) but the midwives in this sample did not demonstrate any obvious signs of burnout either on the questionnaire or during informal discussion.

7.1.1 Education and compliance of midwives

The results demonstrate that some elements of the template were not introduced. Hunt (1997) states that the key to improving women's satisfaction with their birth experience would appear to be organising care so as to provide continuity of carer. The new template advocated that women should have met their community midwife antenatally and that there would be continuity of carer postnatally. It seems that all midwives were not given a clear brief about the study, especially the rationale behind the new template. Although the midwifery staff who were working on the postnatal ward prior to the implementation of the new template were given a verbal briefing and written

information about the study, much of the focus of the briefing was on the recruitment of women. Furthermore, the majority of midwives rotate throughout the hospital, increasing the chances of different midwives working on the postnatal ward during the actual study period. This may have influenced midwife compliance resulting in failure to implement elements of the template.

Education and compliance of midwives is essential sucessfully to implement change of any nature. The way in which midwives viewed the priorities for the new template and approached decisions about visiting options may have influenced the outcome of the study. In deciding whether or not to visit, some midwives gave the women the choice and said that in these instances most women opted to have a visit. The notion of informed choice within the context of maternity services is a complex one, and evidence suggests that many midwives are selective about the choices and information they offer women (Hillan et al, 1997). Schien (1986) believes that in managing any change, the employee has to become motivated to unlearn something and then replace it with new learning. It appears from the findings that midwives may not have unlearned all aspects of the existing visiting policy.

7.1.2 Midwives' receptiveness to change

Recent policy changes suggest that midwives should be open to change and should be able to consider alternatives in how maternity care is delivered (DOH 1993; S0HHD 1993). Responding to this, midwives have embarked on midwifery-led units, team midwifery and other patterns of care delivery aimed at increasing choice, continuity and control for women. Not surprisingly, many of these initiatives have encountered problems. In this study certain elements of the planned change did not appear to take place. Midwives were asked to see all their potential postnatal clients antenatally, so that they would be visited by a known midwife. There was no change in the number of midwives who saw potential postnatal clients between Phase 1 and Phase 3; 40 percent of women had not met the community midwife before she visited postnatally. The reasons for this are unclear but may be because midwives did

not know about the women, their workload may have been too great or they may not have perceived meeting the woman antenatally as a priority.

Although efforts were made to introduce the change as efficiently as possible, certain issues may have influenced the outcome. Those responsible for the management of the service felt that a change in the delivery of community postnatal care was required but midwives seemed less sure. Many felt that given the existing midwifery staffing levels and resources, the existing model of postnatal care was the most appropriate. Some midwives were clearly concerned that other work would be 'forced' on them as a result of the reduction in the number of postnatal visits. Rumours about the viability of the study hospital were rife when the new template of postnatal care was being introduced. This may have impacted on the outcome of the study. In planning the change, midwifery managers should have considered the climate within the hospital and met with the midwives to discuss their fears and concerns.

For many midwives the focus of the new template seemed to be the number of postnatal visits. This paper identified that many midwives made what appeared to be 'comfort' decisions – that is, making a decision which was considered 'safe' or was unlikely to lead to complications. For example deciding to carry out another visit may have been an easier option than not visiting as it involved less critical thinking. In some instances the midwives may have made extra visits because they knew the woman would like a visit even though there was no real justification for one. Much of the evidence surrounding this type of decision-making is anecdotal, although the retrospective review of notes highlighted that quite a few women in both phases requested extra visits in spite of any clinical or professional reason to do so. Furthermore, midwives said that if women called for advice, they felt obliged to visit 'just in case'. In all cases where a woman is cited as requesting a visit, that visit took place. This is an indication that midwives complied with the women's wishes irrespective of need or priority. Fear of litigation is recognised as a concern for many midwives. It may be that midwives feel 'safer' carrying out routine but possibly unjustified procedures

and visits, as they will then have the evidence to highlight that all was well at the time of the visit.

Effective change management requires adequate planning. The introduction of the new template did not result in a change of outcomes; however, the study did highlight the importance of considering all aspects of the change and the skills required to implement change.

7.2 The New Template

Although women in Phase 3 were more likely to receive three visits than those in Phase 1, continuity of carer was not improved. The new template of postnatal care involved discharge of low-risk women from hospital within forty-eight hours of delivery. The postnatal visiting policy was to be based on individual need (maternal or neonatal), but each woman would have a minimum of three visits from the community midwives after discharge. The same midwife would visit the woman each day.

7.2.1 Patterns of postnatal visiting

Although selective postnatal visiting began over a decade ago the profession seems none the wiser about the rationale or basis for selective postnatal visits. Garcia et al (1994) suggested a need to have more concrete evidence to support postnatal visiting policies. Implicit in the UKCC Code of Practice 1986 and the subsequent UKCC statement regarding total postnatal care (1992) is the notion of professional judgement. It was hoped that this study would highlight the use of professional judgement concerning the timing and the content of each visit. The findings of this study and in particular the information from the focus group study, correspond with findings of another study (Procter, 1998) which suggest that there is a mis-match between what women want postnatally and what midwives think women want. This mis-match further compounds midwifery professional judgement about patterns and content of postnatal visits.

Midwives saw breastfeeding support as one of the most demanding and time consuming elements of postnatal care; however there is little evidence of other

factors which impact on care provision. Indeed method of feeding did not appear to impact on the pattern or amount of postnatal visits. Few midwives actually spoke of aspects of postnatal care that women said mattered to them other than support of breastfeeding. Midwives acknowledged that the presence of a problem would necessitate an extra visit – but did not make this explicit in the casenotes. Midwives agreed that if the woman requested a visit they were likely to visit a woman irrespective of whether or not she was perceived to 'need' a visit. Furthermore, midwives said that if a woman called the helpline for advice they felt obliged to visit the woman just in case there was something wrong. This suggested that although midwives didn't think a visit was needed they still did one – just in case. More work on decision-making and confidence building might make midwives more confident to justify the omission of a visit. Midwives tended to share their workload as a means of supporting each other.

Twaddle et al (1993) introduced a model of individualised postnatal care whereby midwives planned postnatal care at the first postnatal home visit. The study did not identify a template for postnatal visits to low risk women, but the outcome was a reduction in postnatal visits and the number of midwives to visit. In Twaddle's study the average number of visits was quite high to start with, thus making a reduction easier. In Phase 1 of the study midwives said that increased workload had already necessitated the introduction of selective visiting, thus making further reduction more complex. There was no difference in the average day of discharge from the community midwives and most women agreed that the midwife stopped visiting at just the right time.

7.2.2 Nature and Content of Postnatal Visits

One way of establishing possible reasons for the visit was to investigate the content of the postnatal visit. Review of hand-held notes and the information contained in the maternal and midwives questionnaire suggested that there was not a specific routine examination which occurred daily. Midwives did not carry out a routine a head-to-toe examination on every woman. In the majority of cases midwives carried out complete examinations on babies at every visit

and full examinations on women on at least 50 percent of the visits. What is not clear from the casenotes or the midwives questionnaire is the basis for doing or not doing a routine head-to-toe maternal examination. Three midwives did not examine the abdomen, six did not examine the lochia and a ten did not examine breasts at every visit. Yet 15 said they assessed maternal wellbeing and the psychological condition of the mother at every visit. The conundrum is that there little evidence to support or refute whether every woman who is visited should have a routine head-to-toe examination. Hand-held records do not routinely provide insight into rationale for visits or investigations.

Crucial to developing clinical decision-making is an awareness of the rationale for investigations. In many instances the early stages of postnatal complications will be identified on clinical examination (sub-involution of the uterus, abnormal lochia). In the majority of instances the evidence from the casenotes does not explain why visits took place, an assumption can be made that if nothing abnormal was written in the notes, then it was a 'routine' visit. However given the high proportion of women who experience postnatal complications, work is required to establish whether there is a case for routine head-to-toe examination of the mother and baby at every visit. Although midwives say that certain observations are unnecessary at every visit, in practice these are often carried out routinely at every visit (Marchant & Garcia, 1995). Marchant & Garcia (1995) suggest that although midwives try to give care on an individual basis, they may be inhibited by constraints of tradition and routine.

Midwives reported that they took swabs from 30 percent of women on at least half the visits, however this was not substantiated by the review of casenotes or data in the maternal questionnaire. Nor were midwives' reports that blood was taken from 30 percent of babies in Phase 3 on at least half the visits supported by analysis of the maternal questionnaires and casenotes. Review of these suggested that the likely percentage for this was 11 percent, including bloods taken for Guthrie and serum bilirubin. There were some other discrepancies between what midwives said they did and information obtained

from maternal questionnaires and casenotes, for example, watching a baby feed and checking babies' skin. It is unclear why there are discrepancies in what midwives perceived they did and what the evidence highlighted.

7.3 What Women Want

The new template of postnatal care was introduced in order to meet women's' needs and expectations. Evidence from the focus group data, postnatal questionnaires and other studies indicate that women want to be treated as individuals, receive appropriate support and education and where possible know the midwife who will visit them postnatally. Implicit in this is continuity of care and the avoidance of conflicting advice which might influence maternal satisfaction and induce stress. Integral to ensuring satisfaction is ensuring that all women are aware of the care options available to them (Singh & Newburn, 2000). Sixteen percent of women in both phases of the study said that they had received conflicting advice from midwives. This was frequently mentioned in relation to breastfeeding. Women in the both studies highlighted the importance of receiving the right education and information about motherhood and baby care

7.3.1 Continuity of care

Women said having more than one midwife visit did not affect their care, but if given the choice they would have preferred to see the same midwife throughout. Women did not seem to find the lack of continuity of care a problem, indeed the majority said that it did not affect their care. Nevertheless, in response to the Likert statement, the majority of women agreed or strongly agreed with the statement;

> *"it is important to have the same midwife visiting me in my own home."*

Although the template planned for all women to be seen by the same known midwife, findings suggest that midwives made little attempt to achieve this. All recent evidence suggests that, if the midwife and woman are familiar with each other, postnatal visits are more targeted to the needs of the woman and midwives visits are shorter (March & Sargent 1991). Midwives said that they tried to meet the woman antenatally yet the evidence from the women did not support this. Midwives are aware of the importance of continuity of care

(Hillan et al, 1997) yet in this study they did not ensure that this was achieved. Most midwives were clear that women need continuity, yet a striking number of midwives did not know the woman they visited postnatally and vice versa. In discussions with the midwives they highlighted that although each individual midwife may attempt to ensure that she maintains continuity of carer, external organisational factors (such as increased workload, sleep day for midwives who were called out, sick leave) may hinder this. This then impacts on midwife and client satisfaction. If the existing organisation of how community postnatal care is delivered militates against continuity of carer, then any organisational change must be a factor in strategies to enhance continuity of carer. The new model of postnatal care anticipated that by reducing the number of core postnatal visits continuity of carer would be improved. However, as no other element of the organisation of community midwifery care altered, this made such a goal less likely.

Implicit in the introduction of change is an understanding of how the proposed change will impact on how care is organised, planned and delivered. The midwives in the study hospital worked very closely together, fostering good communication and collaboration. The nature of the midwifery workload necessitates a sharing of responsibilities and commitment. Community midwives depend on each other for cover if they are called out to a DOMINO or home confinement. Midwives are aware of the caseload of colleagues and are quick to offer to take an extra visit from a midwife who, for a variety of reasons, may have more postnatal visits than others. A typical example of altering visiting strategies is when a midwife has a postnatal visit in a particular neighbourhood and another midwife also has a woman in the same area. If the workload is heavy, one midwife will visit both women in order to reduce travel and time, making planning continuity of carer difficult.

Sandall (1997) highlighted that continuity of care was as important to midwives as to women. But in a cohesive group of midwives who work in geographically defined areas, this may not be the case. Midwives seemed to make decisions about care based on workload and the needs of colleagues. Even though midwives demonstrated an awareness of the importance of

continuity of carer to women, the collective priority to 'cover' the postnatal visits, seemed to supersede the aim of achieving continuity of carer. Clearly an awareness by the midwives of the evidence surrounding women's needs and continuity of carer does not automatically result in altered practice and the implementation of evidence-based care. In this study midwives either differentiated between the available evidence to support women's views and the pragmatics of delivering such care or prioritised care according to workload and routine.

Continuity of care is high on the management and consumer agenda (SOHHD, 1993; HMSO, 1993), but this is not always reflected in practice. Midwives or midwifery management may not always listen to what women are telling them, nor do they truly know what women want. Some midwives rationalised their care provision by saying that women do not complain about care, yet did not differentiate between the levels of satisfaction expressed by women. This study and others (Audit Commission, 1997; Penney et al, 1999) highlight that although women do not actively complain about their postnatal care, when asked, many cite dissatisfaction with elements the postnatal care they received.

7.3.2 Preparation for parenthood

In spite of antenatal education about the postnatal period women may not be prepared for this life event (Nolan, 1995). As hospital postnatal care is generally not well evaluated, women may find the transition to motherhood more difficult than initially anticipated. All documents which discuss the needs of users of the maternity services highlight the importance of accurate information, informed choice and a high standard of preparation for parenthood education. On discharge from hospital the only point of contact and professional support for many women is the community midwife. Women in both studies acknowledged the limited information available about the transition to motherhood and other aspects of the postnatal period. However, the results from the postnatal questionnaires in both Phases highlighted the value women placed on the support and education given by community midwives and suggests that the deficit in parenthood education is redressed at least in part, by the work of the community midwives.

7.3.3 Satisfaction with care

It is difficult to develop adequate models to measure and describe the complexities of satisfaction. Traditionally, forced choice questionnaires have been used to measure satisfaction with childbirth and maternity care. However, although these are easy to administer, it is difficult to get a true measure of satisfaction (Procter, 1998). Examples of the richness of data which can be obtained from women about their childbirth experiences are evident in findings of the focus group interviews which are presented in Chapter Five.

Postnatal care is described as the most poorly evaluated element of maternity services (Audit Commission, 1997). The reasons for this may be varied. Lumley (1985) argues that hospital surveys may not always give accurate responses as the woman is a patient and may fear retribution or neglect for herself and/or her baby. She may also give answers that she feels the researcher wants to hear. This could be a reason why criticism of maternity care is mainly surrounding the postnatal period. Although this would not preclude women from adversely commenting on other elements of the maternity service at this time, women may feel 'safe' to make adverse comments once their maternity care episode is completed.

Satisfaction with the model of maternity care experienced does not imply that women would opt for the same model if they were given a choice (Graham, 1997). Although women said they were satisfied with the model of postnatal care they received, the responses to Likert statements suggested otherwise. During the focus groups some women expressed discontent that they had not been informed of all the care options open to then. This is amplified in maternity care which involves the birth of a healthy baby. Safety is cited as the single factor that matters most to women, their family, providers and purchasers, and yet many clinical trials do not always address it (Graham, 1997). Women said that they were satisfied with their care. Neverthless, it was clear that, given the option, women had other preferences which would have enhanced satisfaction. In this study the questionnaire data highlighted

that although women said seeing different community midwives did not affect their care, in the Likert statements, almost all women said that they would have preferred to see the same midwife for the whole community care episode.

When asked if other care options would have increased their level of satisfaction, a significant proportion agreed. This does not necessarily imply dissatisfaction, merely recognition that there may be better options. Just how feasible it is to offer a variety of care options, such as postnatal visiting until six weeks postnatally, use of breastfeeding support workers, and social support in the home within existing resources, is debatable. In offering alternatives of care achievability must be ensured. Maternity care involves variables which must be taken into account in planning the delivery of services. While in theory it may be possible to juggle working hours and on call in order to facilitate women's needs, the sustainability of such efforts must be questioned.

The degree to which women are given an active say in decisions about their care influences satisfaction levels (Brown & Lumley, 1998). This study found that many midwives continued to make decisions about care without apparently involving the woman. Over 40 percent of women said that the decision to stop visiting was made by the midwife alone. Yet most women said that the number and duration of visits was right and that they were satisfied with the care they received.

For midwives, job satisfaction may influence the care they offer women. A Scottish study identified that the most important predictor of midwife satisfaction was autonomous practice and the most important factor in midwifery dissatisfaction was over-involvement of medical staff (Hundley et al, 1994). In the UK, postnatal care, and in particular community postnatal care is an area where midwives generally practise autonomously without medical direction or involvement. Midwives were satisfied with their job but many expressed frustration about the organisation of their day (coming into the office at the start and end of each day) and the amount of 'on call' required of each of them.

7.3.4 Telephone helpline

Accessibility to support and information is considered to be an important element of postnatal care (Rush & Kitch, 1991). A telephone helpline was introduced in Phase 3 of the study. Although access to a telephone helpline cannot be seen as the panacea, most women valued having it – a view supported by other studies (Hamilton, 1998). On the other hand, midwives in this study were less sure of its value. They stated that the telephone line necessitated extra postnatal visits. The evidence suggests that if women know about the telephone helpline, they will use it (Rush & Kitch, 1991). The telephone helpline was introduced without any education of staff. Midwives concern about telephone queries may be due to inexperience in dealing with problems and making decisions over the telephone rather than face-to-face.

7.3.5 Requests from women for more visits

Questionnaire data identified that a small number of women who used the telephone support line requested an extra visit, although the woman-held notes did not reflect this. Furthermore a proportion of women who received an extra visit in Phase 3 did so because they had requested one. What is unclear from the casenotes and questionnaires is the rationale for the requested visits. It appears from the data that if a woman requested a visit, she received one – irrespective of need. This may call into question the decision-making skills of the midwife – is she making a 'comfort' decision to visit and what are the implications of such a decision? Comfort decisions tend to be associated with junior midwives because of inexperience and lack of confidence, but in this study the majority of midwives were very experienced and had spent many years as community midwives.

7.4 Evaluating Care

Evaluation of existing patterns of care and estimation of consumer satisfaction is a prerequisite of any change in patterns of care delivery. The new template of postnatal care was based on the professional views of practising midwives and was informed by evidence from other studies in postnatal care (Twaddle et al, 1993; Marsh & Sargent, 1991; Ball, 1994), yet the template was not fully implemented. A possible reason for the outcome could be that fundamental

problems associated with dissatisfaction in the puerperium, such as inadequate preparation for parenthood and postnatal stay in hospital were not addressed.

While it is accepted that the most effective way to evaluate maternity care is by means of a RCT, this is not always a pragmatic or appropriate approach (Garcia, 1997 in Campbell & Garcia, 1997). This study was designed to evaluate both models of community postnatal care in terms of clinical effectiveness and their acceptability to women and midwives. The pattern of the new template of care was based on evaluations of generic postnatal care elsewhere, (Bick et al, 1997; Murphy-Black, 1989; Turnbull et al, 1995) and the suggestions and recommendations of the community midwives, staff and management of the hospital.

Although evaluation of hospital postnatal care was not an objective of this study it was deemed appropriate to include one question about length of stay in hospital. In keeping with the findings of other maternity care studies women took the opportunity to write comments expressing concern about hospital postnatal care (McCourt & Page, 1996; Audit Commission, 1997; Bostock, 1993). The quality of hospital postnatal care does not appear to have improved in recent years, in spite of relatively constant adverse criticism. In a recent audit of maternity services in Scotland, (Penney et al, 1999) a high proportion of women who made unfavourable comments about their care did so about hospital postnatal care. Adverse comments related to poor staffing levels, hospital food, ward environment and poor advice and support.

In considering why research evidence which informs midwifery care is not implemented, factors such as change management, education, motivation and decision-making skills must be considered. Recent Government reports (SOHHD, 1993; DOH, 1993) all advocate a change in the delivery of maternity care but the midwifery culture is reactive and in many instances changes are imposed without due evaluation of existing models of care. Postnatal care, and in particular community postnatal care appears to lack a sound evidence base. (Bick et al, 1997). Recently, fear of litigation has begun to impact on midwifery practice (Symon, 1998). In this study midwives may

have had covert concerns about safety especially as evidence to support the view that fewer visits will not detract from care, is minimal (Twaddle et al, 1993). For many midwives, custom and accepted practice may be difficult to overcome. Midwives perceived that they introduced the new template of care although evidence did not support this. Midwifery is steeped in tradition and asking midwives to break away from this may induce stress and concern.

7.5 The Midwife

Midwives in both Phases of the study were satisfied with their job and the postnatal care they offered women, but expressed concern about the ever increasing burden being placed on them. Over the last few years an increased emphasis has been placed on improving the experience of childbirth for women. Experience has demonstrated that changing patterns of maternity care to increase efficiency and effectiveness must be implemented within finite resources. A concern for the profession is the sheer volume of change occurring within the maternity services and the subsequent impact of this on care providers (Audit Commission, 1997). The cumulative impact of these changes on midwives and the care they offer women has not been fully investigated.

This study identified that, irrespective of the template used, midwives were satisfied with the postnatal care they provided for women. Midwives identified their priorities and what they perceived to be women's priorities for postnatal care. However, these differ from priorities for care identified by the women in the study (see Chapters Five and Six). Discrepancies in midwife/woman perceptions and expectations may lead to dissatisfaction. The findings of this study reflect the misinterpretation of what women want. Evidence to support midwifery knowledge and care is growing yet many midwives fail to recognise the significance of research findings. In order to improve care and clinical outcomes midwives must listen to what women are telling them.

7.5.1 *Evaluation of midwives' perceptions of both models of care.*

The midwives who participated in this study were content and satisfied with their role and the support they offered postnatal women. In Phase 1 the midwives agreed that they were happy with their job, but there was a subtle shift in levels of satisfaction between Phases 1 and 3, although this was not statistically significant.

Although there was no difference in the mean number of postnatal visits and other outcomes, women in Phase 3 were more likely to be visited three times than those in Phase 1. The majority of the midwives in Phase 3 believed that they had introduced the new template and cited ways through which they utilised the time freed up from the extra postnatal visits. This perception may, in part, be due to the 'expectation effect' of subjects knowing they are taking part in a research study (Rankin, 1999; Jamieson & Flood, 1993). Furthermore, three midwives in Phase 3 stated that, as they already gave individualised postnatal care they had not altered their practice with the new model.

7.5.2 *Midwives satisfaction with the postnatal care they gave to women*

There was no significant difference in the satisfaction levels of midwives between both models of care. Other studies, which implemented new models of care within existing resources, had similar findings (Hogg, O' Connor, Tucker, Miller & Barnett, 1998). In keeping with other studies, although midwives fully supported the new template, once the protocol was introduced, its acceptance and implementation by the midwife was less clear (Garcia et al, 1994). Unease about selective postnatal visiting is evident in the literature (Hamilton, 1998), yet the midwives did not voice this concern. The template had the support and agreement of all midwives and should have avoided some of the pitfalls of introducing a change in service. Nonetheless, the introduction of the template took some time to be fully operational and midwives were unsure how much autonomy they had in decisions about visiting.

The majority of midwives felt that time was freed for other aspects of their job. Efforts to quantify these suggested that antenatal care and clerical work took up the bulk of the released time. The proportion of time the midwives said they devoted to postnatal care changed between Phase 1 and Phase 3. Midwives in Phase 3 said they were likely to devote less time to postnatal care and the average number of postnatal visits per midwife per day dropped from seven to 5.5. Midwives said that the length of a Phase 3 postnatal visit was slightly longer. On reviewing the figures kept by the community services manager, the average number of postnatal visits by each midwife per day did not alter between the phases, nor were midwives perceptions supported by evidence from the postnatal questionnaires or an audit of community postnatal visits. Midwives may have anticipated these consequences following introduction of the template and believed that this was the information the researcher required. Or, midwives might genuinely believe that these changes in care delivery and organisation had occurred as a result of the new template. Finally, subtle changes may have occurred in the midwife's practice which were not reflected in the outcomes, for example, midwives may have given more thought to the rationale for visits/investigations than previously, even though the actual number of visits remained the same. Midwives' satisfaction with their role in postnatal care is influenced by a variety of things: the women they care for, their professional responsibility, accountability and autonomy and relationships with colleagues and other health care professionals, to name but a few.

Midwives agreed that there should be more interdisciplinary teamwork but seem opposed to more General Practitioner involvement in maternity care.

7.5.3 Midwives' views of how their working pattern influences job satisfaction and impacts on the postnatal care they deliver

Midwives expressed dissatisfaction with certain elements of their job. Many felt that the organisation of workload and 'on call' should be reviewed. Although midwives worked in geographically based groups, this structure altered at weekends and in the event of staffing problems or irregular workloads. Thus, midwives explained that, while in theory, working in a specific geographical area was helpful and improved continuity of care and

carer, other factors impinged on this. This was accepted policy and no midwife questioned this routine or its impact on the quality of postnatal care provision. Furthermore on introducing the new template, cognisance should have been paid to existing practices and routines which might impact on postnatal care provision.

Similar concerns about the nature and amount of 'on call' are reflected throughout the profession. In many instances midwives are required to be 'on call, this includes on call for DOMINO and home births as well as postnatal women. Midwives are not well paid for being on call, a token fee of circa £7 is paid, and if midwives are called out they are either paid or get time back for the duration of the callout. This arrangement is not satisfactory for many midwives; because of family and home commitments many would prefer not to do 'on call' (Hillan et al, 1997). In many instances delivery of a quality and cost effective maternity service is dependent on the goodwill of the midwives and the amount of 'on call' they are willing to do. Many studies highlight that the nature of a midwife's 'on call' commitment influences her job satisfaction and may increase the chances of 'burnout' (Hillan et al, 1997; Sandall, 1997, Hogg et al 1998).

Some midwives expressed frustration (verbally and in the questionnaire) about 'having to come into the hospital every morning'. The routine is that all community midwives come into the office each morning at 08.30 hours and usually leave again between 09.00 and 09.30. This time is used to plan their day and communicate with colleagues. Some midwives said that this daily meeting was a waste of time and it would be more effective to make better use of existing communication methods such as contact by their mobile telephones, but other midwives argued that women did not want them visiting them too early. As the organisation of community care seems to be based on 'office hours' perhaps there is a case for midwives looking at a new way of working which might avoid some of the pitfalls they describe. It may be that, in order to work more efficiently, midwives have to alter their hours and nature of how they work in order to meet consumer needs. Reviewing the nature and organisation of how midwives work is advocated by strategic

planners and policy papers such as the Framework for Maternity Services (Scottish Executive, 2001).

7.5.4 Midwives perception of their role and the postnatal care they offer women

Procter & Wright, (1998) supported health service evidence that emphasised the importance of soliciting consumer views. Yet eliciting consumer and provider views of a service, although important, will not give the whole picture. Professionals may be influenced by the halo effect of a new model of care and consumers adopt the 'what is must be best' view identified by Porter and McIntyre in 1984. Gaps exist between the professional and client' views of a quality service (Procter, 1998). The disparity between midwives' and women's expectations of postnatal support is a concern, and is supported by the focus group data. Examples of this might be different midwives visiting and increased workload necessitating shorter visits. Midwives must be able to look at the bigger picture in terms of the type and quality of postnatal care they provide to women. From a professional stance it is not acceptable to consider only individual practice; all external influences which impact on care provision and maternal satisfaction must be considered. In reaching decisions about visiting, part of the decision should be based on ensuring continuity of care.

The demographic characteristics of the midwife respondents were consistent with the national trend (Hillan et al, 1997). All the respondents were experienced community midwives who agreed that at least 50% of their working time was devoted to postnatal care, yet, their perceptions of what the postnatal women wanted differed substantially from women's expectations. This study throws light on the mismatch of consumer-provider expectations and perceptions of postnatal care.

7.5.5 Midwives perceptions of what women want

The rhetoric suggests that midwives are aware of the needs and expectations of women. A specific question in the midwives' questionnaire asked about arrangements for postnatal visiting. Most midwives (75 percent) agreed that they arranged for a specific day, but did not specify a time (although many did

say morning or afternoon). This is not supported by evidence from the maternal questionnaires, postnatal focus groups or NCT data (Singh & Newburn, 2000) In the Likert style statements in the questionnaire (Appendix 1X& X) 50 percent of midwives agreed that some women do not want the midwife to visit them postnatally and over 70 percent of midwives said that a lot of women are not prepared for coming home from hospital, while 92 percent and 89 percent of women respectively disagreed with those statements. Midwives stated that they provided sufficient postnatal support for women and indeed the maternal questionnaire data reflects this. The DOMINO and home birth rates in the study hospital are, it is argued, a reflection of the population requirements rather than unavailability of the services. Many midwives do not offer alternative delivery options because of the organisational and cost implications for midwives (Hillan at al, 1997). This results in a lack of informed choice for women who might have opted for alternative models of care.

7.5.6 Decision making skills of the midwife

This study endeavoured to identify what the midwives saw as priorities for the timing, rationale, content and duration of the postnatal visit. This work was hindered by the paucity of information in the hand-held notes. Midwives said that psychological support was the most important element of postnatal care and a key factor in deciding whether other visits were required. In recognising psychological and emotional support as a key component of postnatal care, the question of whether midwives have the necessary counselling skills to support this role must be addressed. In the first part of the study (Phase 1) midwives did not routinely identify reasons for postnatal visits. In Phase 3 reasons were identified only if it was an extra visit, however even then reasons were often omitted. In many instances the quality and nature of information in the maternal hand-held notes was poor. Casenote data highlighted that midwives did not make explicit mention of the types of support provided to women, thus making the assessment of what happened at the visit difficult. Maintaining client confidentiality, lack of time, failure to understand the implications of poor recording keeping may be among the reasons why midwives do not write note detailed notes.

Tinkler & Quinney (1998) and Drayton (1997) highlighted the limited research evidence about midwifery practice and, de facto, the decision-making skills of midwives. Clinical midwifery judgements are dependent on the knowledge and experience of midwives and are part of the decision making process (Coiffi, 1998). These judgements are made following the gathering and evaluation of client/patient information. Page, Phillips & Drife (1997) argue that decisions about care are informed from three sources: the woman's values and wishes; clinical assessment; research evidence. In order to reach a decision midwives require the skills of counselling, critiquing the evidence and clinical assessment. Although clear about some issues which influenced midwives' decision to visit, they were vague about the timing and content of visits. The midwives said that newly discharged women or women with problems were visited over the weekend and did not see anything strange about using different sets of decision making criteria for visiting depending on the day of the week, a view supported by Hamilton (1998).

In order to understand the nature and organisation of community midwifery, the researcher spent a good deal of time observing, listening, talking to and generally being with community midwives. The information gleaned from this proved invaluable and gave an added insight into the nature and organisation of community midwifery care as well as providing information about midwives attitudes and the factors which influence community midwifery provision. Midwives used the morning and afternoon time in the office to write records, organise their workload and discuss cases with colleagues. It soon became clear that although each midwife had an individual caseload, this was very flexible and altered from day to day. The key issue for midwives was that all the 'work' was covered each day. For midwives this meant that all clinics were staffed and all postnatal women who needed a visit would get one. Consequently and sometimes unwittingly, compromises were made and midwives shared caseloads in order to provide a more efficient service.

At no time during these discussions did the issue of continuity of carer arise. For all midwives, the crucial element was that women who needed support and a visit would get one irrespective of who actually visited. The midwives made decisions about visiting based on their perceptions of each individual woman's needs, not on their ability to visit personally. This is an important issue when understanding why continuity of carer is not achieved. Midwives viewed the visit as being more important than who visited. It is unclear whether midwives ever discussed possible visit options and the implications of these options with postnatal women.

The information obtained from this study adds to the debate surrounding the decision-making skills used by midwives. Midwives seemed capable of making choices and decisions about visits in consultation with other midwives, especially when workload was heavy or during the weekend when staffing was less. However, this skill is not always transferred to the clinical area, nor is there an indication of whether these decisions were the correct ones

The ever-increasing fear of litigation combined with inexperience as the key professional and decision-maker may result in some midwives using criteria to minimise the risk of litigation rather than clinical criteria for decisions regarding care. A study of interpersonal communications in hospital suggested that midwife referrals to doctors were because midwives 'bottled out' of making decisions or required reassurance that their decision was the correct one (Brownlee, McIntosh, Wallace, Johnston & Murphy Black, 1996). In 1997 Smith, argued that midwives should change their attitudes to care by exercising a 'letting go' of what is considered safe practice. Smith (1997) argued that midwives should hand back control to the woman. They should apply their knowledge of the woman, combined with utilisation of the telephone, to assess the frequency and necessity of visits.

Recently, midwifery literature suggested that midwives practise aspects of postnatal care without any firm evidence to support what they do (Renfrew, Hannah, Albers, Floyd, 1998). A discrepancy between postnatal care actually given by midwives and what the midwives considered appropriate care to give

was highlighted by Marchant et al, (1995). Although Marchant identified that midwives were able to prioritise care on paper, in practice this did not appear to be the case.

The complexity of midwifery decision-making skills in relation to postnatal care is compounded by accepted practice and tradition. Data from a recent study (Pope, Cooney & Graham, 1998) suggested that many midwives felt it was difficult for them to be confident and competent to provide midwifery care in all spheres of practice. However, Chapter Six highlights that the midwives in this study were experienced and confident in their ability to care for women in a variety of settings. Because community staffing at the weekend is reduced, midwives visit only newly discharged women or women who are experiencing specific problems (Poole, 1999). A cultural change amongst midwives is required, regarding decisions about the amount, timing and content of postnatal visits.

Not enough work has been done to decipher factors which influence the knowledge process and decision making skills of midwives. Although collectively, community midwives express confidence in their ability to carry out holistic care for women, it may be that the nature of community midwifery affects confidence levels, which in turn impacts on midwifery decision making skills. Work is needed to investigate how working alone as a community midwife impacts on confidence, and delivery of midwifery care. The development of educational support for midwives so that they will have the knowledge and confidence to deliver individualised care as they see fit would go some way towards developing the critical skills required to provide individualised holistic care.

The reluctance by midwives to commit their rationale for postnatal visits is interesting and difficult to explain. Research into postnatal care is still incomplete and midwives may not feel that there is sufficient evidence to suggest that omitting visits or certain observations will do no harm to women. Finally, midwives may lack the confidence and/or decision-making skills to omit an element of care because of fear of litigation. In conclusion, despite

the evidence, many midwives may find it easier to carry out a postnatal visit or certain observations rather than justify not doing so.

7.5.7 Midwives impact on postnatal care provision – The social role of the midwife

While maternal physical and emotional wellbeing is implicit in the role of the community midwife, the documentation in the casenotes does not demonstrate the interaction that takes place between the woman and the midwife during specific observations and investigations. Midwives are in a unique position to promote maternal health and wellbeing, but crucial to achieving this aim is a good relationship with the woman. For many professionals there is a fine line between a close professional relationship and getting emotionally involved. The dilemma for midwives of being a professional versus being a friend has been acknowledged in the literature (McCrea & Crute 1991). The nature of community midwifery may be that midwives receive minimal feedback for the effort they put in. As home care is quite personal community midwives may feel increased pressure to act as ambassadors for the maternity services. The relationship between a woman and her midwife engenders trust and increases the woman's sense of control (Summers- Marr, 1996) but it is unhealthy for the association to develop into a dependency relationship (Sandall, 1998). A crucial element of postnatal care is to educate and empower women. Thus, if midwives allow or encourage the woman to become dependent on her, this can have a detrimental effect on woman and midwife (Sandall, 1997).

Midwives sometimes identified client choice or request as a reason for a postnatal visit. Recent studies highlight the importance of facilitating the woman to make her own decisions about care (Penney et al, 1999). The information that a midwife gives a woman is a matter of professional judgement. However, the midwife must ensure that there is a balance between the support given to allow the woman to feel in control and the element of choice which allows the woman to decide whether she wants to exercise that control or leave the decision making to the midwife (Richards, 1997). There seems to be a conflict of opinions: midwives said that they facilitated the woman in making her own decisions about care but women said that in twenty

five percent of cases the midwife made the decision about when next to visit, and in forty three percent of cases it was the midwife alone who decided when to stop visiting the woman.

7.5.8 Other professional involvement

The debate over who should be the lead professional in maternity care continues. As well as having an identified obstetrician most women continue to be under the care of their General Practitioner. Payment for General Practitioner maternity services comprises specified elements; in order to claim payment for postnatal services the General Practitioner must visit the women at home before the fifteenth postnatal day (Rosser, 1998). The majority of women in this study had a general practitioner courtesy visit while the midwife was still visiting, resulting in an overlap of care. In many instances the General Practitioner visited on the same day as the midwife. Whilst the visit may be important to the woman and the General Practitioner, the timing and content should be reviewed in order to avoid duplication of resources.

7.6 Other Factors Which May Have Influenced The Outcome

The main factors which might have influenced the outcome have been discussed but there are certain issues which may have contributed to the outcome and deserve to be addressed.

7.6.1 Method of feeding

There is a perception by midwives that feeding method influences patterns of visiting. This is supported by the audit of postnatal visits in the study hospital (1996) which found that women who were breastfeeding were likely to receive more visits than those who bottle-fed. Interestingly, there was no difference in the average number of midwife visits to breast and bottle-feeding women in this study. In Phase 3 of this study, breastfeeding was identified by the midwife as one of the main reasons for extra postnatal visits; yet this was not supported by data from the hand held notes or questionnaires. But what the study does not tell us is the amount of time midwives spent with breast versus bottle-feeding mothers. The perception by midwives that breastfeeding women require and get more midwifery support is not validated by the findings of this

study. The attrition rate for breastfeeders was minimal whilst in hospital. In contrast Foster, Ladar & Cheesbrough (1997) found that twelve percent of women who commence breastfeeding discontinue by the time they leave hospital.

A higher proportion of women in Phase 3 changed from breast to bottle-feeding during the course of the study although it was not possible to elicit why this occurred. A number of studies suggest that health professionals have a relatively small influence on a woman's decision relating to feeding (Purtell, 1994; Wylie & Verber, 1994; Libbus, 1992). By four weeks postnatally (at the time of completion of the questionnaire) and in spite of the drive to encourage and promote breastfeeding, a similar number of women were breastfeeding in both Phases (37% versus 36.3%). Phase 3 of the study coincided with a drive in the study hospital to obtain Baby Friendly Hospital Status. Midwives expressed concern that the drive to improve breastfeeding rates might result in more work, reflected in a greater number of visits for community midwives, but this did not happen. Chaffer (1999) cautions that although all midwives should inform women of the benefits of breastfeeding, this should not result in making women feel guilty if they opt for bottle-feeding. In the free-text some women who bottle-fed said that they felt like second-class citizens, saying that breastfeeding women got more attention and support. These perceptions may increase the number of women who opt to breastfeed in the hope that that they will get sufficient attention from the midwives. Hughes & Rees (1997) established that although women had some knowledge of bottle-feeding; they still required education and support in feeding and baby care. Women commented that acts of affirmation such as showing women how to make up feeds and giving them advice would have been appreciated and would have given women an opportunity to ask questions about baby care.

The rationale behind the decision to breastfeed will influence success rates and outcome and may explain why so many women stop breastfeeding when the community midwife stops visiting. In encouraging women to breastfeed, midwives should also reflect on the unsupported and multiple roles that many

women have which makes breastfeeding more challenging (Dykes & Griffiths, 1998). Women in this study identified clear practical reasons for breastfeeding. Hughes & Rees (1997) established that women's decisions about feeding method are usually well informed and those who choose to bottle feed base their decisions on practical considerations within their social and environmental context. Assumptions that people who choose to bottle feed do so because they do not understand the benefits of breastfeeding have largely been refuted (Foster et al, 1997; Dykes & Griffiths, 1998; Hughes & Rees, 1997). Questionnaire data showed that women who bottle-fed identified pragmatic reasons for doing so. Furthermore women who bottle-fed demonstrated that they too needed appropriate education and support in the puerperium.

7.6.2 Duration of breastfeeding support

Although not supported by the women who completed the postnatal questionnaire, women who participated in the focus group study said they would prefer visits spread out over a longer period of time. This supports other work (McCourt & Page, 1996; GGHB 1999; Garcia, Redshaw, Fitzsimons, 1998). Midwives said that women who breastfed get more support, but in reality this did not happen. Some women may require midwifery support past the average eleven day discharge for a variety of reasons, breastfeeding being just one. However, the value of increased visits and support to women who are not fully committed to breastfeeding is difficult to establish. It is difficult to justify extra postnatal visits on the grounds of feeding support alone and the question of whether breastfeeding support is an appropriate use of midwifery time must be addressed.

One of the most common reasons given by this sample for not breastfeeding was that other people can help to bottle-feed, a view supported by other studies (Foster et al, 1997). In order for midwives to support and encourage breastfeeding there must be recognition of issues which impact on the initiation and duration of breastfeeding, such as the correlation between antenatal intention and postnatal behaviour. Tones & Tilford (1994) suggested that, while providing information may result in a change in attitude and

intention, other facilitating factors were required to produce a change in behaviour. This is a view supported by Auerbach (1990) who advocated the encouragement of breastfeeding through health education but suggested that this would be ineffective if the breastfeeding mother was not supported and if breastfeeding was not protected in the wider society.

In her study McInnes (1998) established that women in less affluent areas were less likely to breastfeed successfully. McInnes established that using Breastfeeding Helpers may have encouraged women to initiate breastfeeding. In this study women who breastfed in Phase 1 stayed in hospital longer, but this was not the case for Phase 3. The perception by midwives that they devote more time to breastfeeding women may influence their attitude towards breastfeeding women. During Phase 3 midwives said that they were working hard to improve breastfeeding rates. Therefore, it was particularly disappointing to note that at the time of completion of the questionnaire the same percentage of women were breastfeeding in both groups. This may indicate that irrespective of support, only highly motivated women will continue to breastfeed past four weeks.

The study found that many women continued to breastfeed whilst the community midwife was visiting but stopped once the midwife stopped visiting. This could indicate that day eleven is the wrong time to withdraw support or that the women were waiting for the midwife to stop visiting before they ceased breastfeeding.

7.6.3 Hospital postnatal care

The purpose of postnatal care is to facilitate rest and prepare the woman for the demands of motherhood once she goes home. Yet there is no evidence to support this view. Women in the focus group study (Chapter Five) said that education and support while in hospital did not meet their expectations, and many confessed to being unable to rest while in hospital.

Women in both Phases of the study expressed concern about postnatal care and in particular hospital postnatal care, especially the lack of education and

support given to first time mothers. A number of women expressed concern about the differences in support that were offered to breastfeeding women. Women placed particular emphasis on lack of support and parentcraft education by hospital midwives. It may be that a prolonged stay in the postnatal ward increases anxiety and exhaustion levels (Jackson, 1996). Much of the evidence that is available about hospital postnatal care highlights high levels of noise, inability to rest, poor support and education as reasons for maternal dissatisfaction (Ball, 1994; McIllwaine et al, 1993; Audit Commission, 1997). Although the existing evidence suggests a poor quality hospital postnatal care service, little has been done to rectify this (Audit Commission, 1997; McCourt & Page, 1996; Ball, 1994; Penney et al, 1999). A reduction in hospital postnatal stay may not be the answer. The introduction of interventions, which support women whilst in hospital and following discharge home, should be encouraged and audited.

In criticising the hospital element of postnatal care, women said that the ward was very busy and midwives had more pressing priorities than to support them. If a woman lacks confidence and perceives the midwife to be busy she may feel uneasy about 'bothering' the midwife in case her concern/question is perceived as trivial (Marchant, 1997). Further research is needed to identify the optimum postnatal support in hospital (Audit Commission, 1997), this should include looking at how workload is organised, manpower and skill-mix.

7.6.4 Duration of postnatal stay in hospital

The average stay in hospital remained the same between the phases and women in both Phases of the study were satisfied with their length of stay in hospital. The reasons for this were unclear especially as all the women in the study were low risk. The Scottish Policy Review (SOHHD, 1993) suggested that early postnatal discharge would improve consumer satisfaction. In a Glasgow study which investigated midwife led care, the average day of postnatal discharge in both groups (midwife managed versus routine care) was 3.3 (Shields et al, 1997). However that study also highlighted that postnatal care was the most expensive element of maternity care (Twaddle, 1996). The

reduction in the average length of hospital postnatal stay has been a gradual one from 5.5 days in 1977 (Macfarlane & Mugford, 1984) to 3 days in 1998 (ISD, 1999). In this study, the average day of discharge from the postnatal ward was day three in both Phases. This suggests that women in this study, although low risk may have stayed in hospital longer than average. It is not possible to identify why women who remained in hospital longer than three days did so, especially as there was no difference in the feeding method of those who stayed past three days.

7.6.5 Study method

Midwives said that their practice had altered over the twelve-month period before Phase 1 commenced and it was likely that it continued to alter throughout the study period. A randomised controlled trial methodology would have shed more light on the impact of altering templates of postnatal care. However it was decided from the outset that a RCT was not appropriate because of the small number of community midwives, the difficulties in organising work in two different ways and the possibility of contamination because midwives might impose the template on the non-experimental group. In order to establish midwives views of the care they offered, questionnaires were considered the most pragmatic approach, yet using a case-study approach would have given an added insight into all the dimensions of being a community midwife.

7.6.6 Chance

Another possible reason for the study outcome is chance. Statistical advice was sought from a medical statistician. The sample size allowed for a detection of differences in satisfaction rates of women. It was not likely the results presented in Chapter Six occurred by chance as the sample size gave an 80% power to detect differences in satisfaction, at the 5% level, a difference of 0.25 units between the mean satisfaction scores of the two groups, assuming a within group standard deviation of 0.75 units.

7.7 Summary

The study demonstrated no difference in outcomes between both Phases, but it found that women appreciated and were generally satisfied with community

postnatal care. It is likely that a complexity of factors influenced the outcome of the study. The management of change, the limited information given to midwives in the Trust, the nature of community midwifery provision and women's expectations and needs may have influenced the outcome. Basic principles of change such as involving all midwives whether directly or indirectly involved with the change should have been adhered to.

Until now the evidence to support the continuation of postnatal home visiting has been minimal, but the results of this study support the case for continued postnatal care in the community. Although there was no significant difference in the mean number of postnatal visits to women during the study period, in Phase 3 there was an increase in the proportion of women who received three visits suggesting a more selective visiting approach. Furthermore, irrespective of Phase and parity, postnatal women valued and were satisfied with postnatal community care. Women were happy to have the community midwife visiting them in their own home and appreciated having a contact number to phone for advice and support. On average, women saw two midwives postnatally and said that this did not affect their care. However, many women agreed that it would be better to see the same midwife postnatally. The dilemma for providers of maternity services is to prioritise the aims of maternity care, and in doing so, come to an accepted definition of excellence in care. Women were happy with the care they received but given other options may have chosen alternatives and been more satisfied. However the options offered to women must be realistic and within existing resources. It is neither wise nor appropriate, to offer women care options which places undue practical, organisational and economic burdens on the service. Consequently, in suggesting alternative care options which stretch existing resources, there is a risk that the option offered might not be achievable and thus result in maternal dissatisfaction and professional frustration.

This study aimed to improve continuity of care as well as maternal satisfaction, yet women in both Phases were seen by an average of two midwives and many had not met their community midwife prior to the postnatal visit. Reasons for this have already been discussed, but given the

nature and organisation of midwifery care, it may be inappropriate to continue to aim for continuity of carer when this may not be achievable. The feasibility of having continuity of carer within the existing organisational structure must be considered. Midwives argued that varied workloads, added demands of the role, supporting colleagues and ensuring an equal distribution of work all contribute to the problem of ensuring continuity of carer. Although midwives acknowledged the importance of ensuring continuity of care and carer in the community setting, in practice many midwives did not appear to consider this when planning their daily workload.

Although satisfied with their care, women continued to express concern about the conflicting advice especially in relation to breast-feeding. The most recent audit of maternity services in Scotland continues to recommend continuity of carer although the evidence suggests that this is a difficult concept to achieve (Penney et al, 1999). Continuity of carer did not improve following introduction of the new template of care. Problems associated with lack of continuity of carer centre around conflicting advice and the confusion and anxiety this causes. This study did not find an increase in maternal satisfaction following the introduction of the new template. This finding differs from other studies which identified the increase in maternal satisfaction as the main finding (Hundley et al, 1994; Shields et al, 1998).

The study highlighted dissatisfaction with hospital postnatal care. Reasons for this were varied but a commonly cited reason was associated with poor staffing levels. In keeping with other studies, (Penney et al, 1999) women stated that the wards were understaffed and midwives very busy. Consequently, many women did not ask the questions that concerned them, resulting in anxiety, resentment and dissatisfaction. Before introducing any new pattern of community postnatal care/support, attention should be paid to the existing problems such as poorly evaluated preparation for parenthood courses and hospital postnatal care. If women feel they are not prepared for parenthood, or that their support and care whilst in the postnatal ward is poor, this may impact on overall maternal satisfaction.

Increasing the breastfeeding rate is high on the NHSiS agenda and not surprisingly midwives were encouraged to devote time and effort to this cause. Nevertheless, in spite of the increased midwifery support and encouragement the rates have not risen significantly. Although midwives are the people best placed to encourage breastfeeding antenatally and in the immediate postpartum period, it is important to take a broader view of factors which encourage the initiation and continuation of breastfeeding. Innovative initiatives which provide support for breastfeeding mothers, encourage mothers to choose to breastfeed, encourage society to accept breastfeeding as the cultural norm and put in place facilities or legislation that promote, support and protect breastfeeding must be developed and evaluated.

CHAPTER EIGHT

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This study raises many questions for the midwifery profession and policy makers. In debating the outcome of introducing the new template of postnatal care, fundamental questions about the organisation of care, daily routines, values, priorities and perceptions of community midwives should be addressed. Postnatal morbidity is a public health concern (Louden, 1986) and therefore any interventions or new models of postnatal care should be evaluated to ensure that they aid the transition to motherhood and improve maternal and neonatal wellbeing. This study set out to introduce a new model of community postnatal care within existing resources which was woman centred, effective, efficient and improved continuity of care for postnatal women. Chapter Seven discussed the findings of the study but this chapter reflects on the findings and considers why they may have occurred.

8.1 Conclusions And Implications

8.1.1 Organisation of the study

The previous chapters explained that funding for this study was from a Chief Scientist Office, Research Training Fellowship. Consequently the study had to fulfil certain criteria and take place within a specific time-scale. The constraints of time and finances restricted the study method. The researcher had six months to write the full research proposal and obtain ethical approval. The research proposal, along with the relevant tools and ethical approval was submitted to the CSO in March 1997. The proposal was approved and the researcher was given 18 months to complete the research and submit the final report. The allocated funding and related time-scale influenced the organisation of the study and the study method. The research methods were selected in order to achieve the study objectives within the allotted time-scale. The focus group study was crucial in providing an insight into primigravid women's perceptions and experiences of postnatal care. The information gained would have been enhanced by conducting focus groups with

multigravid women, as this would have added another dimension to the information collected.

Although the time spent by the researcher with the community midwives gave added insight to the study, it would have been helpful to have had this insight before the study started, as elements of the methodology and possibly other aspects of the study might have altered. Use of a case study approach to establish midwives' views and experiences of the postnatal care they provide, would have given a valuable insight into how community midwifery care is managed and delivered.

Although community midwives were involved in planning the new template, it is unclear whether all the implications and requirements of the new template were adequately addressed. Furthermore little attention was paid to each midwife's priorities for care or the impact that team working has on individual practice. Although 'team midwifery' was not practised in this hospital, midwives worked in supportive teams. Within each team midwives had individual caseloads until team priorities took over. Consequently midwives seemed to work on two organisational levels although the position of women's priorities within this framework was unclear.

With regard to a comparison of the two models of care, although it was recognised that a randomised trial would have been the best method, it was not feasible to conduct such a study because of the time-scale available. The before and after study was achievable within the time-scale. Questionnaires were selected to obtain both midwife and maternal information as they were considered likely to yield the maximum amount of information within the budget and time-scale. Interview data would perhaps have yielded richer data but was not feasible given the constraints of time and money.

8.1.2 The management of change

Any change in outcome was subtle and the midwives did not introduce the new template of care. Thus a conclusion might be that the development and introduction of the new template of care was not managed well. The

community midwives were actively involved in the change process while midwives in other areas of the hospital were less involved. In hindsight all midwives and individuals who were likely to be directly or indirectly involved, should have had the same input as the community midwives. The obstacles which existed towards the implementation of the new template of care were some of the very reasons why the model was introduced in the first place. Women's decisions about whether or not to be visited are complicated by their confidence levels, knowledge of the midwife, ability to care for the baby, coping strategies, emotional well being and the way in which the midwife suggests or offers visits. If choices and options are to be routinely offered to women then cognisance must be taken of the impact of the outcomes of these on service provision.

8.1.3 Failure to listen to women

This study found that many women are still keen for the professional to help in decision-making or possibly even make the decision for them. This study found a discrepancy between what the women said they wanted and what the midwives thought the women wanted. Confusion, mixed signals combined with poor listening skills result in a mis-match of expectations and care delivery.

A consequence of not listening to women is a difference in perceptions and expectations. As with other studies, (Procter, 1998) the women in this study were concerned about getting information and support to help them gain confidence to adjust to motherhood while midwives considered feeding and emotional support as priority areas. Findings from a recent study (Lavender, Walkinshaw, Walton, 1999) support the view that health professionals and even interested lay groups do not necessarily know what women want. Listening to and interpreting what women say is an essential component of midwifery care. Although midwives may believe that they listen to, and understand the women they care for, this study and others suggest a gap in perceptions.

Although the midwives believed that women were in control of their care and were offered choices about their care, women were less sure. Continuity of care developed as a theme as the study progressed. A consequence of more than one midwife visiting was the potential problem of conflicting advice experienced by women. Midwives, on the other hand, were of the view that seeing more than one community midwife was not a problem as they felt that all midwives offered a similar standard of support and information. In reality, conflicting advice, mixed messages and different midwives visiting, added to the stress and confusion experienced by many postnatal women. Although women in this study said that seeing the same midwife did not affect their care, when given the choice of seeing the same midwife postnatally, most agreed that they would prefer this.

8.1.4 Preparation for parenthood

In keeping with other work (Nolan, 1998), this study found that women in the antenatal period tend not to be interested in parenthood education at the time when they receive it. However, women in the postnatal focus group study said that they were not prepared for parenthood and they did not get enough antenatal preparation. The women who participated in the postnatal focus groups criticised hospital postnatal care especially the lack of support and education available.

Women in the focus group study said that basic information-needs such as information about lochial discharges was not given to them. Gauging the information and education requirements of each woman is an essential component of midwifery care. Although the rationale is still unclear, it seems that pregnant women are more focused on the birth of the baby and play little attention to education about the puerperium and the transition to motherhood during the antenatal period. Although evidence to support this view is beginning to emerge (Nolan, 1998), it is becoming increasingly obvious that parenthood education in its present format does not meet the needs of many women. Ways to interest and motivate pregnant women and their partners in the puerperium should be explored.

Midwives must be aware of the factors which impact on women's interest and recall of issues discussed at preparation for parenthood courses. Thus they will be able to incorporate strategies which motivate women to reflect on the postnatal period. Midwives acknowledged the importance of psychosocial support for postnatal women but failed to mention ways in which they might actually support women and their partners in the transition to parenthood. Research is required to identify ways in which midwives can help ease the transition to motherhood for women

8.1.5 Evidence based care

The paucity of evidence related to community postnatal care may be a consequence of its uniqueness to Britain. British midwives have cared for postnatal women in their own homes since the turn of the twentieth century, yet there is little available research material to inform midwifery practice in this area. The midwifery profession is in a difficult position. There is no measure of the existing standard and value of community postnatal care. Thus, midwives lack appropriate evidence to alter the delivery of postnatal care. The problems associated with putting evidence into practice are well documented. When evidence is not available to support aspects of care, the issues are complicated further. This places midwives in a difficult position as they sometimes know intuitively and experientially that an element of care is worthwhile but they lack any evidence to support it.

8.1.6 Community postnatal care

A controversial question is whether community postnatal care in its present format is the most efficient and cost-effective method of supporting women in the postnatal period. The findings of this study demonstrate the value women place on community postnatal care while also cautioning that further evidence is required before suggesting any policy change in postnatal care. The recent evidence from the Confidential Enquiries into Maternal Deaths 1994-1996 (DOH, 1999) highlighted that women still die from complications in the puerperium. This is further complicated by the numbers of women who commit suicide during or shortly after their pregnancy care episode (Robinson 1998). Robinson (1998) argues that low staffing levels on postnatal wards and

cuts in midwives' home visits are reducing the opportunities of identifying and supporting women who are at risk. The concern is that there is no evidence to refute or support this statement. Alexander (1998) cautions that midwives should not stop postnatal investigation without evidence to support this decision.

8.1.7 Obtaining midwives' views

When writing the research proposal, use of anonymous questionnaires was considered the most appropriate method for eliciting midwives' views about the postnatal care they provide for woman. The researcher did not know the community midwives as all initial discussions were with the midwifery managers. The twenty community midwives shared a large office which also doubles as their common room. Once the study started the researcher began to spend a good proportion of time in this office. Within a month it became evident that a case study approach to obtaining midwives' views would have yielded much richer data. Furthermore, getting to know the midwives and the ways in which they worked gave the researcher added insight into the role of the community midwife. A key learning experience for the researcher was recognising that many unanticipated and sometimes external factors can influence how care is organised and practised and that these factors may influence the study outcome.

8.1.8 Community midwives

In spite of increasing workload and demands to broaden their role, while at the same time providing continuity of care, community midwives were happy and satisfied with their job. All the midwives understood the importance of providing the appropriate support and information to new mothers. Many expressed frustration that 'outside' factors impacted on the continuity and care they provided to women. These included factors such as illness, 'on call' and sleep days following 'on call' commitments which resulted in midwives sharing their workload with colleagues, so that women were seen. Consequently, midwives saw women from other caseloads, reducing continuity of carer.

The community midwives working day continues to be based on a traditional model, all midwives work from 08.30 to 16.60 (Monday – Friday), teams share 'on call' for DOMINO and home births. This traditional working pattern, supports traditional models of care. It is worthwhile considering new ways of working which place the woman at the centre of how care is organised, whilst taking into account family friendly policies and the needs of individual midwives.

The part-time nature of midwifery was thought to influence continuity of carer. Eighty percent of the community midwives worked full time and were unable to achieve continuity of carer. This figure is higher than the national average of 50 percent, (Hillan et al, 1997).

All community midwives were experienced and at senior clinical grades (95 percent were 'G' grades). Much of the role of the community midwife is based on care for low risk women and the appropriateness of having the majority of midwives at such a senior grade must be questioned. A review of the skill mix and manpower requirements of community care may result in an alteration of the community maternity care workforce.

8.1.9 The decision making skills of the midwife

The majority of the debate about midwifery decision-making skills took place in Chapter Seven where it was suggested that midwives' decision-making skills in the postnatal period lacked definition and clarity. This may be as a consequence of previous medical domination, a reflection of insecurity, lack of confidence or defensive practice. Evidence from other studies suggests that these problems are not just associated with postnatal care (Penney et al, 1999).

The argument exists that midwives should not alter their practice in accordance with current trends but should be able critically to evaluate their practice in the light of current research. (Barwise, 1998). The shift in the balance of visits between three and four in Phase 3, suggests that midwives did attempt to introduce the new template for 'well' postnatal women. It would be interesting to establish whether it was all or some midwives who altered their

visiting pattern. It was not possible to discern this from the casenotes, especially as more than one midwife tended to be involved in the care. However, review of the available casenotes for the few women in Phase 3 who were seen by the same midwife, suggested that there was a core of four midwives who were more likely to visit the same women on the three occasions.

In keeping with the findings of other authors, the study found little rationale for decisions about care (Poole, 1999). There appears to be a general complacency about postnatal care yet the recent Confidential Enquiry into Maternal Deaths 1994-96 (DOH, 1998) highlighted the importance of vigilance in the postnatal period. It suggested that midwives, general practitioners and other medical staff should be aware of the signs and management of puerperal sepsis, deep venous thrombosis, pulmonary embolism and psychiatric disorders in the puerperium. Midwives should be aware of the possible complications of the postnatal period and frequently use instinct, coupled with professional knowledge and experience to inform their care (Ashcroft, 1998). Their use of instinct may be a reason why documentation about the rationale for visits is so poor. An essential element of sound midwifery practice is talking and listening to women. In attempting to provide choices to women, midwives must spend time with them in order to share information, knowledge, and support (Ashcroft, 1998). Consequently, although a reduction in postnatal visits may be justified, midwives may feel that women need more attention and support from them.

8.1.10 Maternal and neonatal morbidity

It is not possible to accurately compare maternal morbidity rates in Scotland with other Western countries as many do not measure maternal morbidity and those who do use different tools and methods of estimating and recording maternal morbidity (DOH, Ireland 1999; National Centre for Health Statistics US, 1991). Only 32 (ten percent) did not experience any problem postnatally. When asked to compare their health now with how they were before they were pregnant, almost 25 percent said they felt worse or much worse. Similarly, only 26 percent of all babies did not experience any problems postnatally.

What is unclear from this and other studies is the impact of home visiting on the detection and treatment of morbidity. Analysis of the casenotes found that only a small number of women were identified as having problems while the midwife was still visiting, adding weight to the view that midwives should continue to visit for a longer period postnatally. Predictive and interventive models of care need to be explored as a means of supporting women postnatally.

8.1.11 Hospital postnatal care

The majority of women were satisfied with their postnatal care, however, the study found that certain elements of care provision could be improved, especially hospital postnatal care. This concurs with other work (Waldenstrom, Borg, Olsson et al, 1996), which highlighted that positive and negative feelings about care can co-exist. In keeping with other studies (Bostock, 1993; McCourt & Page, 1996; Audit Commission, 1997; Penney et al, 1999) hospital postnatal care was criticised. Criticism about hospital postnatal care centres on what women describe as poor staffing which they rationalise as the basis for poor communication, education and support whilst in hospital. Yet the evidence to support the concern about hospital staffing levels is vague, little work has attempted to evaluate existing maternity related manpower planning models. What is clear, is that it is unacceptable to continue to provide a service which is so heavily criticised in its present format.

Comments in the questionnaire reflected women's perceptions of the 'busy-ness' of staff. First time mothers in particular did not seem to have the confidence to ask the 'busy' midwives questions as they felt that their questions were silly or irrelevant. Work is required to investigate hospital postnatal care and develop a service which addresses the needs of women and their families.

8.1.12 Summary

The existing model of postnatal care (hospital care followed by midwifery community postnatal care) has been in existence since the mid 1930s (Murphy

Black, 1989). Apart from reducing the hospital postnatal stay and introducing a more selective postnatal visiting policy (UKCC, 1992) little attempt has been made to alter the nature and structure of postnatal care for women. In order to develop and enhance care options for postnatal women, policy makers and those who deliver maternity care must have a sound understanding of what women want. This study highlighted that midwives' perceptions of what women want do not necessarily reflect the needs, priorities and expectations of women. Midwives introduced certain elements of the new template to their care. The previous chapters addressed some possible reasons for this, but it is clear that more work is required to encourage midwives to consider the needs and expectations of the women they care for, and to understand the importance of using available evidence to support their practice (Hurley, 1998).

This study differed from other studies as the new template was introduced within existing resources. Community midwives helped design and develop the new template of postnatal care. There was potential for a Hawthorn effect as the midwives knew that the new template of postnatal care was being investigated, yet there was no difference in outcomes. The significance of this is debatable and possible answers might address the experience and self-confidence or possible apathy of midwives. Information to support the decisions about postnatal visits is minimal and firm conclusions about this cannot be reached. In some instances, midwives' perceptions of factors which influenced their workload, were not reflected in the study outcome. The midwives said that breastfeeding was a reason for more visits and support, yet the study findings did not substantiate this.

This study comprised three complementary projects. Although they were distinct pieces of work, the findings of all three interconnected and provided added insight and a clearer picture of community postnatal care as well as postnatal care in general. The background to the study and the methodological, time and funding constraints already mentioned may have influenced the outcome.

In planning any developments in the provision of postnatal care, cognisance must be taken of existing evidence. Findings of the focus group discussions highlighted that women were not prepared for motherhood and the postnatal period. Although there was no difference in outcomes women were very satisfied with the community postnatal care provided by midwives. Midwives applied aspects of the new template of postnatal visiting. Areas such as preparation for parenthood and hospital postnatal care are not well evaluated (Singh & Newburn, 2000). Existing models of care do not always meet the expectations and needs of women. Introducing interventions and support for the postnatal woman and her family may have minimal effect if there are other areas which negatively impact on outcomes and satisfaction.

8.2 Recommendations And Limitations Of The Study

8.2.1 Limitations of the study

The main limitation of this study was the study method. A before and after study design was used to provide the appropriate information within the available timescale and resources. It was also thought that this method would cause least disruption to existing maternity services. A randomised controlled trail would have been the most appropriate way to evaluate the new template, however this would not have been feasible without a complete re-organisation of maternity care delivery within the unit. However, it is not expected that a randomised controlled trail would have altered the written casenote information supplied by the midwives.

Because of the timescale involved in this study the researcher had the opportunity to spend a great deal of time in the study hospital. Much of this time was spent with the community midwives. Although the interaction was very helpful and informative it also meant that the researcher was not entirely divorced from the participants and this could have introduced a bias to the introduction of the template, the interpretation of the results and the discussion.

There was a deficiency in the quantity and quality of written information recorded by the midwives on the maternal hand-held notes. Midwives did not

note duration of, or rationale for, each postnatal visit. Other information recorded was sketchy and often failed to paint a clear picture of the wellbeing of mother and baby. In many instances, it was only in subsequent recordings that any mention of a problem on the previous visit was made. In consequence, it was not possible to identify a rationale for the existing pattern and content of postnatal home visits. Another cause for concern was that 61 sets of notes (15 percent) were missing.

8.2.2 Recommendations

So much is written and debated about the management of change, yet there is constant evidence that change within the health service is not managed well. Amongst other things this study has highlighted the importance of understanding all elements of existing care provision before introducing change. Audit of existing services is not enough; there should be a full scoping of the existing service before any change is planned.

The lack of evidence surrounding use, content and outcome of the routine postnatal check, suggests a need to investigate this examination in more detail. A randomised controlled trial would answer whether there is a need routinely to complete a full head-to-toe examination of mother and baby at every postnatal visit.

Identification of the gaps in knowledge between midwives and women is essential for the development of sound midwifery practice. Midwives must be encouraged to develop listening skills which facilitate interpretation of what women are saying

Although there is much debate about what constitutes evidence-based practice, especially within midwifery, little thought has been given by the profession to facilitate and ensure a level of midwifery practice which responds to the available evidence. The development of a national strategic plan to bring forward the implementation of evidence based practice would go some way towards ensuring a high quality maternity service for women and their babies.

The debate continues about the nature, provision and outcomes of postnatal care. The paucity of research in the field of postnatal care has resulted in changes in practice without any evidence to justify the change. Poorly evaluated hospital postnatal care should not be the sole justification for the current trend to reduce hospital postnatal stay. Work is required to investigate and evaluate the role, function and duration of hospital postnatal care. Identification of research priorities in postnatal care, especially in the field of hospital postnatal care must happen soon.

REFERENCES

Adams H. (1994) Lecture Given at a Study Day for NCT Teachers. October 1994 Birmingham *in* Nolan M 1995 Helping Parents Adapt to Parenthood. British Journal of Midwifery. 3(1) pp 23-26.

Ainsworth J, Wilson P (1994) Would your judgement stand up to scrutiny? British Journal of Nursing. 3:1023-8.

Alexander J. (1998) Confusing debriefing and defusing postnatally: the need for clarity of terms, purpose and value. Midwifery. 14(2); 122-124.

Argyll and Clyde Health Board (1999) Review of Maternity Services in Argyle and Clyde Health Board.

Astbury J; Small R; Brown S; Lumley J (1994) Missing Voices: What Women Say and Do About Depression After Childbirth. Journal of Reproductive and Infant Psychology. 12; 89–103.

Audit Commission (1997) First Class Delivery: A National Survey of Women's Views of Maternity Care. Improving Maternity Care Services in England and Wales. Audit Commission Publications, Abingdon, 1997.

Ball J. (1987) 1st Ed. Reactions to Motherhood: The Role of Postnatal Care. Cambridge University Press.

Ball J (1994) 2nd Ed. Reactions To Motherhood: The Role of Postnatal Care. Books For Midwives Press, Cheshire.

Barber T (1998) Stress and the Management of Change. RCM Midwives Journal. Vol 1, No 1, pp 26-27.

Barbour R (1995) Scottish Consensus Statement on Qualitative Research in Primary Health Care. Dundee: Tayside Centre for General Practice, University of Dundee

Barclay L, Lloyd B (1996) The Misery of Motherhood: Alternative Approaches to Maternal Distress. Midwifery. 12, pp 136-139.

Balla J. (1985) The Diagnostic Process. A Model for Clinical Teachers. Cambridge University Press, Cambridge.

Bar Hillel M (1980) The base rate fallacy in probability judgement. Acta Psychologica. 44 pp211-133.

Barwise C (1998) Episiotomy and Decision Making British Journal of Midwifery, December Vol 6, No 12, pp 787-90

Beaton J, Gupton A (1990) Childbirth expectations: a qualitative analysis. Midwifery. 6 133-139

Benner P (1984) From Novice to Expert: Excellence and Power in Clinical Nursing Practice. Addison Westley Publishing Co., California.

Bennett A (1985) The Birth of a First Child: Do Women's Reports Change Over Time? Birth. 12:12, pp 153-158

Bennett VR, Brown LK (1989) 11th Ed. Myles Textbook for Midwives. Churchill Livingstone.

Bennett VR, Brown LK (1993) 12th Ed. Myles Textbook for Midwives. Churchill Livingstone.

Berryman G, Rhodes M (1991) Early Discharge of Mothers and Infants Following Vaginal Childbirth. Military Medicine. 156: pp 583-584.

Bick D, MacArthur C (1994) Identifying morbidity in postpartum women. Modern Midwife. December 1994 pp 10-13.

Bick D, MacArthur C (1995) The Extent, Severity and Effect of Health Problems After Childbirth. British Journal of Midwifery. 3(1) pp 37-31.

Bick D, MacArthur C (1995) Attendance, Content and Relevance of the 6 Week Postnatal Exam Midwifery. 11 pp 69-73.

Bick D, MacArthur C, Winter H, Fortune H, Henderson C, Liliford R, Gillies A, Gee H, Belfield C (1997) Redesigning Postnatal Care: Physical and Psychological Needs. British Journal of Midwifery. October 1997, 5:10 pp 621-622.

Bick D, MacArthur C, Winter H, Fortune H, Henderson C, Liliford R, Gillies A, Gee H, Belfield C (2000) The comparison of current care with protocol based midwifery-led care beyond twenty eight days. Paper presented at the 8th International Conference of Maternity Care Researchers, University of Glasgow, Glasgow..

Bland M (1987) An Introduction to Medical Statistics. Oxford Medical Publications.

Bostock Y (1993) Pregnancy, Childbirth and Coping with Motherhood: What Women want from the Maternity Services. CRAG Secretariat, Scottish Office, Edinburgh.

Bramadat I, Dreidger M (1993) Satisfaction with Childbirth: Theories and Methods of Measurement. Birth. 20:1 March 1993 pp 22-29.

Britton JR, Britton HL, Beebe SA (1994) Early Discharge of the Term Newborn: A Continued Dilemma. Paediatrics. 1994: 94, 3 291-295.

Brown S, Lumley J (1994) Satisfaction with Care in Labour and Birth – A Survey of 790 Australian Women. Birth. 21:1 pp 4-13.

Brown S, Lumley J, Small R, Astbury J (1994) Missing Voices: The Experiences of Motherhood. p 109, Oxford University Press.

Brown S, Lumley J (1998) Changing Childbirth: Lessons From an Australian Survey of 1336 Women. British Journal of Obstetrics and Gynaecology. 105, 143-155.

Brown S, Lumley J (1998) Maternal health after childbirth: results of an Australian population based survey. British Journal of Obstetrics and Gynaecology. 105, 156-161.

Brown S, Johnson B (1998) Enhancing Early Discharge with Home Follow Up- A Pilot Project. Journal of Gynaecological and Neonatal Nursing. 27 (1) pp33-38.

Brownlee M, Mcintosh C, Wallace E, Johnston F, Murphy-Black T (1996) A Survey of Interprofessional Communication in a Labour Suite. British Journal of Midwifery. 4(9) pp 492-495

Buhler L, Glick N, Sheps S (1988) Prenatal care: a comparative evaluation of nurse-midwives and family physicians. Canadian Medical Association Journal. 139 pp 397-403.

Burns N, Grove S (1993) The Practice of Nursing Research. 2nd Ed. W. B. Saunders. Philadelphia.

Carey MA, Smith MW (1994) Capturing the Group Effect in Focus Groups: A Special Concern in Analysis. Qualitative Health Research Vol 4, No.1 pp 123-127.

Cathcart ED Report of the Committee on Scottish Health Services. (Edinburgh: Department of Health for Scotland (Cmnd. 5204) 1936).

Cartwright A (1988) Interviews or Postal Questionnaires? Comparisons of Data About Women's Experiences with Maternity Services. The Millbank Quarterly. Vol 66, No.1 pp 172-189.

Carty E, Bradley CA (1990) Randomized Controlled Clinical Trail of Early Postpartum Hospital Discharge. Birth 17: pp 199-204, 1990.

Central Midwives Board,(1918) National Archives of Scotland. CMB 1-2, Appendix CMB Report 17th October 1918.

Central Midwives Board (1919) Handbook Incorporating The Rules of the CMB. 5th Edition, London.

Central Midwives Board (1921) National Archives of Scotland. CMB 1/3 Appendix CMB Report 1921.

Central Midwives Board (1935) Handbook Incorporating The Rules of the CMB. 12th Edition, London.

Central Midwives Board Annual Report (1936).

Central Midwives Board (1952) Handbook Incorporating The Rules of the CMB. 20th Edition, London.

Central Midwives Board (1978) Handbook Incorporating The Rules of the CMB Norwich, Hymns Ancient and Modern Ltd.

Chaffer D (1999) Attacks on Nursing and Midwifery Education. British Journal of Midwifery. February 1999 Vol 7, No 2. p72.

Cheyne H, Hillan EM, Morris A, Reid L, Tierney J, Lyall H (1999) Women's Health after Childbirth. Paper presented at the International Congress of Midwives, Manila. 1999

Cleutt E, Alexander J, Pickering M (1995) Is Measuring P N Symphasis Fundal Distance Worthwhile? Midwifery. 11(4) pp 174-183.

Cluett E, Alexander J, Pickering R (1997) What Is the Normal Pattern of Uterine Involution? An Investigation of Postpartum Uterine Involution, measured by the Distance Between the Symphasis Pubis and the Uterine Fundus Using a Paper Tape Measure. Midwifery. 13 pp 9-16.

Cochrane Collaboration (1995) Cochrane Pregnancy and Childbirth Database. Oxford, Update software.

Coiffi J, Markham R (1997) Clinical Decision Making by Midwives: Managing Case Complexity. Journal of Advanced Nursing. 25 pp 265- 272.

Coiffi J (1998) Education for Clinical Decision Making in Midwifery Practice. Midwifery. 14 pp 18-22.

Corcoran S. (1986) Decision analysis: a step by step guide for making clinical decisions. Nursing and Health Care 7, pp 149-154.

Corcoran S, Narayan S, Moreland H (1988) "Thinking Aloud" as a strategy to improve clinical decision making. Heart and Lung the Journal of Critical Care. 17: pp 463-468.

Cottrell B, Grubbs L, (1994) Women's Satisfaction with Couplet Care Nursing Compared to Traditional Postpartum Care with Rooming In. Research In Nursing and Health. 17, pp 401-409

Cox JL, Holden JM, Sagovsky R (1987) Detection of Postnatal Depression: Development of the 10 Item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry. 1987 150: pp 782-786.

Crouch M, Manderson L (1993) New Motherhood, Cultural and Personal Transitions. Gordon and Breach, Australia.

Davis J, Brucker M, MacMullen M (1988) A Study of Mother's Postpartum Teaching Priorities. Maternal and Child Health Nursing Journal. 17, pp 41-50.

Departmental Committee of the Department of Health for Scotland (1924) Report on Puerperal Morbidity and Mortality. Edinburgh, HMSO.

Department of Health (1993) Changing Childbirth: The Report of the Expert Maternity Group (The Cumberlege Report) London, HMSO.

Department of Health (1992) Report of The Confidential Enquiry Into Maternal Deaths In The United Kingdom. 1988-1990 London HMSO.

Department of Health (1998) Report of The Confidential Enquiry Into Maternal Deaths In The United Kingdom. 1994-1996 London HMSO.

Department of Health (1998) Midwifery: Delivering Our Future. Report by the Standing Nursing and Midwifery Advisory Committee. February 1998, London, HMSO.

Department of Health (Ireland) (1999) Annual Report of the Chief Medical Officer. www.doh.ie

Dilorio C, Hockenberry-Eaton M, Maibach E, Rivero T (1994) Focus Groups: An Interview Method For Nursing Research. Journal of Neuroscience Nursing. Vol 26, No 3 pp 175-180.

DiMatteo ML; Kahn KL; Berry SH (1993) Narratives of Birth and the Postpartum: Analysis of the Focus Group Responses of New Mothers. Birth. 20: 4, pp 204-211.

Donaldson C, Hundley V, Mapp T (1998) Willingness to pay: a new method for measuring patients' preferences? Birth. 25: 33-40.

Douglas CA & McKinley PL (1935) Report for the Department of Health for Scotland, Maternity, Morbidity and Mortality in Scotland. Edinburgh, HMSO.

Dow DA (1984) The Rottenrow, The history of Glasgow Royal Maternity Hospital. The Parthenon Press Ltd, Carnforth, England.

Dowell J, Huby G, Smith C (Eds) (1995) Scottish Consensus Statement on Qualitative Research in Primary Health Care. Dundee: Tayside Centre for General Practice, University of Dundee.

Drayton S (1997) The Current Role and Contribution of the Midwife Literature Review. Drayton Associates.

Drew N, Salmon P, Webb L (1989) Mothers', Midwives' and Obstetricians' Views on the Features of Obstetric Care which Influence Satisfaction with Childbirth. British Journal of Obstetrics and Gynaecology. 96, pp 184-188.

Dykes F, Griffiths H (1998) Societal influences upon initiation and continuation of breastfeeding. British Journal of Midwifery. Feb 6(2) pp76-80.

Elbourne D, Oakley A, Chalmers I (1990) Social and Psychological Support During Pregnancy. *in* Chalmers I, Enkin M, Keirse MJNC (Eds) Effective Care in Pregnancy and Childbirth. Oxford University Press pp 221-236.

Evans C (1991) Description of A Home Follow-up Programme for Childbearing Families. Journal of Obstetric and Gynaecological Nursing. 20:2 pp 113-116.

Fellowes D, Horsley A, Rochefort J, (1999) Is continuity of carer a top priority for all women? British Journal of Midwifery. Jan 1999, Vol, 7 No. 1. pp 36-40.

Field P (1985) Parents Reactions To Maternity Care. Midwifery. 1: pp 37-46.

Fishbein E, Burggraf E (1998) Early Postpartum Discharge: How Are Mothers Managing? Journal of Obstetric and Gynaecological Nursing. Vol 27, No 2 March-April pp 142-148.

Fleissig A, Kroll D (1997) Achieving Continuity of Care and Carer. Modern Midwife. August 1997 Vol 7, No 8.

Fleming V (1998) Women-with-midwives–with women: a model of interdependence. Midwifery. 14(3) 137-143.

Frey JH, Fontana A (1991) The Group Interview In Social Research. The Social Science Journal. 28(2) pp 175-187.

Friedlander ML, Stockman SJ (1983) Anchoring and Publicity effects in Clinical Judgement. Journal of Clinical Psychology. 39, pp 637-643.

Garbett R (1994) Changing Philosophy by Group Interviews. Nursing Standard. 8(22) pp 37-40.

Garcia J, Macarthur C (1993) Postnatal Care; Time For A Change. Contemporary Reviews in Obstetrics and Gynaecology. 5: pp 130-136

Garcia J, Marchant S (1993) Back To Normal? Postpartum Health and Illness. *in* Robinson S, Thomson A, Tickner V (Eds) Proceedings of The 1992 Research and The Midwife Conference. School of Nursing Studies, University of Manchester. pp 17-25.

Garcia J, Renfrew M, Marchant S (1994) Postnatal Home Visiting By Midwives. Midwifery. Vol. 10 pp 40 – 43.

Garcia J, Marchant S (1996) Chapter 4 "The Potential of Postnatal Care" *in* Kroll D (Ed) (1996) Maternity Care for the Future - Meeting the Challenge. Baillaire Tindall, London.

Garcia J, (1997) Chapter 5 "Finding out What Women and their Families Think of Maternity Services" *in* Campbell R, Garcia J (1997) The Organisation of Maternity Care – A Guide To Evaluation. Hochland and Hochland Ltd., Cheshire.

Garcia J, Redshaw M, Fitzsimons B (1998) First Class Delivery: A national audit of women's views of maternity care. Audit Commission, London.

Garcia J, Marchant S (1999) Care of the mother after birth. *in* Marsh G, Renfrew M (eds) Community-based Maternity Care. Oxford General Practice Series, Oxford.

Gillerman H, Hicks M, Beckham M (1991) The Postpartum Early Discharge Dilemma: An Innovative Solution. Journal of Perinatal and Neonatal Nursing. 1,5 (1): pp 9-17.

Glazener C, Abdalla M, Stroud P, Naji S, Templeton A, Russell I (1993) Postnatal Care: A Survey of Patient Experiences. British Journal of Midwifery. 1(20) pp 67-74.

Glazener C, Abdalla M, Stroud P, Naji S, Templeton A, Russell I (1995) Postnatal maternal morbidity: extent, causes, prevention and treatment. British Journal of Obstetrics and Gynaecology. Vol. 102 pp 282-287.

Gould D (1986) Locally Organised Antenatal Classes and Their Effectiveness. Nursing Times. 82(45) pp 59-61.

Graham W (1997) Midwife-Led Care. British Journal of Obstetrics and Gynaecology. Vol 104 pp 398-400.

Graham W (1998) The Scandal of the century. British Journal of Obstetrics and Gynaecology. April Vol. 105. pp 375-376.

Gready M, Newburn M, Dodds R, Gauge S (1995) Birth Choices: Women's Expectations and Experiences. National Childbirth Trust, London.

Gready M, Buggins E, Newburn M, Draper J, Fletcher G, Dodds R, Wang M (1997) Hearing It Like It Is: Understanding the Views of Users. British Journal of Midwifery. Vol 5 (8) pp 96-100.

Greater Glasgow Health Board (1999) Maternity Care Strategy.

Green JM, Coupland VA, Kitzinger JV (1988) Great Expectations: A Prospective Study of Women's Expectations and Experiences of Childbirth. Child Care and Development Group, University of Cambridge.

Green J M, Coupland VA, Kitzinger JV (1990) Great Expectations: Experiences and Psychosocial Outcomes of Childbirth: A Prospective Study of 825 Women. Birth. 1990 17(1): 15-24.

Greenbaum TL (1988) The Practical Handbook and Guide to Focus Group Research. D C Heath & Company, California.

Gunn J, Lumley J, Young D (1998) The Role of the General Practitioner in Postnatal Care. (Views of male and female GPs on what should take place at routine 6 week check ups) British Journal of General Practice. Sept 48 (434) pp 1570-1574.

Gupton A, McKay I (1995) The Canadian Perspective on Postpartum Home Care. JOGNN Vol 24 No 2 pp 173-179.

Hamilton M (1998) Patterns of Postnatal Visiting: The Views of Woman and Midwives. British Journal of Midwifery. Jan (1998) Vol 6, No 1 pp 15-18.

Handler A, Raube K, Kelley M, Giachello A (1996) Women's satisfaction with prenatal care settings: A focus group study. Birth. 23;1 March pp 31-37.

Handfield B, Bell R (1995) Do Childbirth Classes Influence Decision Making About Labour and Postpartum Issues? Birth. 22:3 September, pp 153-160.

Hansard, Commons, 1936-1937, Vol 319, 28 January, 1937, Cols. 1099-1154.

Harrison EF (1987) The managerial decision making process. Houghton Mifflin, Boston.

Henderson C (1997) What's Happening To Postnatal Care? British Journal of Midwifery. October 1997, 5(10) pp 608.

Henschel D, Inch S (1996) Breastfeeding: A Guide For Midwives. Books For Midwives Press, Cheshire.

Hillan E (1991) Issues In The Delivery of Midwifery Care. Journal of Advanced Nursing. 17. pp 274-278.

Hillan E, McGuire M, Reid L (1997) Midwives and Woman Centred Care. RCM Scottish Board, Edinburgh.

Hiser PL (1987) Concerns of Multiparas During the Second Postpartum Week. Journal of Obstetric, Gynaecologic and Neonatal Nursing. 16 pp 195-203.

Hodnett ED (1987) Support for Caregivers during Childbirth. *in* Enkin MW, Keirse MJNC, Renfrew MJ, Nielson JP (eds) Pregnancy and childbirth module. Cochrane Database of Systematic Reviews Review No 03871. Also Social and professional support in childbirth. *in* Enkin MW, Keirse MJNC, Renfrew MJ, Nielson JP (eds) 1995. A Guide to Effective Care in Pregnancy and Childbirth. 2nd Edition, Oxford University Press, Oxford.

Hodnett ED (1993) Support from caregivers during childbirth. *in* Enkin MW, Renfrew MJ et al, (eds), Pregnancy and Childbirth Module "Cochrane Database of systematic reviews" Review No 03871. 12 May 1993. "Cochrane updates on disk" Disc Issue 2, Update software, Oxford.

Hogg M, O'Connor P, Tucker J, Miller R, Barnett C, (1998) Evaluating the Introduction of Team Midwifery in Ninewells Hospital (1996-1997), Final Report. Dundee Teaching Hospitals NHS Trust.

Holden JM, Sagovsky R, Cox JL. (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal. 298: pp 223-226.

Hosein M (1998) Home Birth: Is It A Real Option? British Journal of Midwifery. 6(6) pp 370-373.

Hughes K, Young W (1990) The relationship between task complexity and decision making consistency. Research in Nursing in Health. 13, pp 189-197.

Hughes D, Dumont K (1993) Using Focus Groups to Facilitate Culturally Anchored Research. American Journal of Community Psychology. 21:6, pp 775-806.

Hughes P, Rees C (1997) Artificial Feeding: choosing to bottle feed. British Journal of Midwifery. 5(3) pp 137-141.

Hundley V, Cruickshank F, Milne J, Glazener C, Lang G, Turner M, Blyth D, Mollison J (1994) Midwifery managed delivery unit: a randomised controlled comparison with consultant led care. BMJ 309: pp 1400-1404.

Hundley V, Cruickshank F, Milne J, Glazener C, Lang G, Turner M, Blyth D, Mollison J (1994) Satisfaction and continuity of care: staff views of care in a midwife –managed unit. Midwifery. 11: pp 163-173.

Hunter M (1994) Counselling in Obstetrics and Gynaecology. British Psychology Society.

Hunt S (1997) The challenge of change in the organisation of midwifery care *in* Karger I, Hunt S (1997) Challenges in Midwifery Care. Chapter 12, pp 165-187, Macmillian Press.

Hurley J (1998) Midwives and Research Based Practice. British Journal of Midwifery. 6:5 pp 294-7.

Information and Statistics Division, Common Services Agency for the Scottish Health Service. (1970) Scottish Health Statistics, HMSO.

Information and Statistics Division, Common Services Agency for the Scottish Health Service. (1981) Scottish Health Statistics, HMSO.

Information and Statistics Division, Common Services Agency for the Scottish Health Service. (1988) Scottish Health Statistics, HMSO.

Information and Statistics Division, Scottish Executive (1996).

Information and Statistics Division, Scottish Executive (1999).

Isabella LA (1990) Evolving interpretation as change unfolds: how managers construe key organisational events. Academy of Management Journal. 33.1 pp 7-41.

Jackson J (1996) Postnatal Care in Hospital. British Journal of Midwifery. Vol 4, No 1 pp 40-41.

Jacoby A (1987) Women's Preferences For and Satisfaction With Current Procedures In Childbirth – Findings From A National Study. Midwifery. 3 pp 117-124.

James M, Hudson C, Gebski V, Browne L, Andrews G, Crisp S, Palmer D, Beresford J (1987) An Evaluation of Early Postnatal Transfer Home with Nursing Support (1987). The Medical Journal of Australia. 147: pp 434 - 438.

Jamieson JL, Flood KR (1993) Experimental and Observational Research Methodologies. *in* Seraganian P Exercise Psychology - The Influence of exercise on psychological processes (Ed) John Wiley & Sons, New York.

Jasson M (1985) Early Postpartum Discharge. American Journal of Nursing. May pp 547- 550.

Johnston RB (1995) The Zone of Tolerance: Exploring the Relationship Between Service Transactions and Satisfaction with Overall Service.

Jones J (1988) Clinical reasoning in nursing. Journal of Advanced Nursing. 13, 185-192.

Kaufmann T (1998) The Challenges Ahead: A Briefing on Current Issues Facing Midwives. Midwives April 1998 Vol. 1 No. 4 pp 105 106 RCM.

Kenny P, King MT, Cameron S, Shiell A (1993) Satisfaction with postnatal care – the choice of home or hospital? Midwifery. 9: pp 146-153.

Kitzinger J (1994) The Methodology of Focus Groups: the Importance of Interaction Between Research Participants. Sociology of Health & Illness. 16:1, pp 103-121.

Kitzinger J (1995) Introducing Focus Groups. British Medical Journal. 311, pp 299-302.

Klein M, Gauthier R, Robbins J (1994) Relationship of episiotomy to perineal trauma and morbidity, sexual function and pelvic floor relaxation. American Journal of Obstetrics and Gynaecology. 171 (3): pp 591-598

Kreuger RA (1994) Focus Groups: a Practical Guide for Applied Research. Newbury Park, CA, Sage Publications.

Kroll D (Ed) (1996) Maternity Care for the Future - Meeting the Challenge. Baillaire Tindall, London.

Kvist L, Persson E, Lingman G (1996) A Comparative Study of Breast Feeding After Traditional Postnatal Hospital Care and Early Discharge. Midwifery. 12 pp 85-92.

Laryea M (1989) Midwives and Mothers Perceptions of Motherhood. *in* Robinson A, Thomson A (eds) Midwives Research and Childbirth. Vol 1 Chapman and Hall.

Lavender T, Walkinshaw S, (1998) Can Midwives reduce Postpartum Psychological Morbidity? A Randomised Trial. Birth. 25: 4 December 1998.

Lavender T, Walkinshaw S, Walton I (1999) A Prospective Study of Women's Views of Factors Contributing To a Positive Birth Experience. Midwifery. 15, pp 40-46.

Leach J, Dowswell T, Hewison J, Baslington H, Warrilow J (1998) Women's Perceptions of Maternity Carers. Midwifery. 14; pp 48-53.

Lemmer C M (1986) Early Discharge Outcomes of Primaparas and their Infants. Journal of Obstetrical, Gynaecological and Neonatal Nursing. July Aug 1986 pp 230-236.

Lewis P (1998) "Boundaries To Practice: When Is A Midwife Not A Midwife?" Midwives. February 1998 Vol. 1 No 2 pp 60-61.

Libbus MK (1992) Perspectives on common breastfeeding problems. Journal of Human Lactation. 8(4) pp 199-203.

Likert R. (1932) A Technique For Measuring Attitudes. Archives of Psychology. 140 pp 1–55.

Lock M, Joel R, (1999) Higher Neonatal Morbidity after routine early hospital discharge: are we sending newborns home too early? Canadian Medical Association Journal. 161: pp 249-253.

Lothian Health Council (1992) Women's views of maternity Services in Lothian. Lothian Health Council, Edinburgh.

Lothian Health Council (2000) Women's views of maternity Services in Lothian. Lothian Health Council, Edinburgh.

Lumley J (1985) Assessing satisfaction with childbirth. Birth. 12, pp 141-145.

Lumley J (1997) Commentary: Reaching Parts That Other Methods Miss. Birth. 24:4 December 1997 pp 221-222.

Louden I (1986) Obstetric care, social class, and maternal mortality. British Medical Journal. 293: pp 606-608.

Louden I (1987) Puerperal Fever, the streptococcus, and the sulphonamides 1911-1945. British Medical Journal. 293: pp 485-490.

Louden I (1992) Death in Childbirth. Clarendon Press, Oxford.

MacArthur C, Lewis M, Knox EG (1991) Health after Childbirth. British Journal of Obstetrics and Gynaecology. Vol 98 pp 1193-1195.

MacFarlane A, Mugford M (1984) Birth Counts, Statistics of Pregnancy and Childbirth. HMSO, London.

MacIntosh JA (1993) Focus Groups in Distance Nursing Education. Journal of Advanced Nursing. 18, pp 1981-1985.

Macleod -Clarke J, Maben J, Jones K (1996) The Use of Focus Group Interviews in Nursing Research: Issues and Challenges. Nursing Times Research. 1:2, pp 143-152.

MacKenzie WL, (1917) Report on the Physical Welfare of Mothers and Children. Vol.3. Scotland. p268 The Carnegie United Kingdom Trust, 1917, Dunfermline.

Marchant S, Garcia J (1995) What are we doing in the postnatal check? British Journal of Midwifery. 3(1): pp 34-38.

Marchant S (1997) Postnatal care and the 'busy hurrying midwife' Midwives Vol 110 (1319); p 308.

Marchant S (1999) Routine assessment of postpartum uterine involution and vaginal loss and the relationship of these observations to morbidity. Unpublished PhD Thesis. University of Portsmouth.

Mander R (1995) The relevance of the Dutch system of maternity care to the United Kingdom. Journal of Advanced Nursing. 22 (6) pp 1023-6.

Mansion L, McGuire M (1998) Factors which influence women in their choice of DOMINO care. British Journal of Midwifery. Oct. 1998, Vol 6, No. 10: pp 664-668.

Margolis LH (1995) A Critical Review of the Studies of Newborn Discharge Timing. Clinical Paediatrics. 1995, 34: pp 626-32.

Margolis L, Kotelchuck M (1996) Midwives, Physicians and the Timing of Maternal Postnatal Discharge. Journal of Nurse Midwifery. Vol 41, No 1, Jan/Feb 1996.

Marris P (1986) Loss and Change. Routledge, Kegan Paul, London, *in* Karger I, Hunt S, (1997) Challenges in Midwifery Care. Chapter 12, pp165-187, Macmillian Press.

Marsh J, Sargent E (1991) Factors Affecting the Duration of Postnatal Visits. Midwifery. 7 pp 177-182.

Martell L, Imle M, Horwitz S, Wheeler L (1989) Information priorities of new mothers in a short stay programme. Western Journal of Nursing Research. 11(2): pp 320-329.

Martell L (1998) Heading towards the New Normal. Paper presented at the 7th International Conference of Maternity Care Researchers, Bergen, Norway.

Mason V (1989) Women's Experiences of Maternity Care - A Survey Manual. HMSO, London.

Mason J (1996) Qualitative Researching. pp127-128 Sage Publications, London.

Maternity Services (Scotland) Act 1937. [1 Edw. 8. & 1 Geo. 6. Ch. 30.]

Matthews D (1995) Birth of A Midwife/Obstetrician. The Lancet. Vol 345 (8949) pp 532.

McCourt C, Page L (1996) Report of the Evaluation of One to One Midwifery Practice. Wolfson School of Health Sciences, Thames Valley University, London.

McCrea H, Crute V (1991) Midwife/Client Relationship: Midwives' Perspectives. Midwifery. 7, pp 183-192.

McGinley MC (1993) Professional Day Paper - commitment to change. Midwives Chronicle. 106: pp 42-44.

McGinley M, Turnbull D, Fyvie H, Johnstone I, Maclellan B (1995) The Development of the Midwifery Development Unit at Glasgow Royal Maternity Hospital. British Journal of Midwifery. 3: pp 362-371.

McGregor L (1994) Short, Shorter, Shortest: Improving the Hospital Stay for Mothers and their Newborns. American Journal of Maternal Child Nursing. 1994, 19, 2 pp 91-96.

McIllwaine G, Cole C, Twaddle S (1994) Increasing Choice In Maternity Care In Scotland. Scottish Needs Assessment Programme. University of Glasgow.

McInnes R (1998) The Glasgow Infant Feeding Action Research Project: an evaluation of a community based intervention designed to increase the prevalence of breastfeeding in a socially disadvantaged urban area. PhD Thesis. University of Glasgow.

McKim E (1995) The Transition to home for mothers of healthy and initially ill newborn babies. Midwifery. 11 (4) pp 184-194.

McVeigh C (1997) An Australian Study of Functional Status After Childbirth. Midwifery. 13, pp 172-178.

Mercer RT (1985) The Process of Maternal Role Attainment at One Year. Nursing Research. 34, pp 198-204.

Montgomery E, Alexander J (1994) Assessing postnatal uterine involution: a review and a challenge. Midwifery. 10(2): pp 73-86.

Morales-Mann (1989) Comparative Analysis of the Perceptions of Patients and Nurses about the Importance of Nursing Activities in the Postpartum Unit. Journal of Advanced Nursing. 14 pp 478-484.

Moran C, Holt V, Martin D (1997) What Do Women Want To Know After Childbirth. Birth. 24;1 pp 27-34.

Morrell CJ, Spiby H, Crowther S (1997) Postnatal Social Support - Counting the cost. British Journal of Midwifery. 5:10 pp 613-615.

Morrell CJ, Spiby H, Stewart P, Walters S, Morgan A (2000) Costs and benefits of community postnatal support workers: a randomised controlled trial. Health Technology Assessment, NHS, R&D HTA Programme.

Morse J (1991) Qualitative Nursing Research - A Contemporary Dialogue. Sage Publications, London.

Munro Kerr JM, Haig Ferguson J, Young J, Hendry J (1923) A combined textbook of Obstetrics and Gynaecology. Churchill Livingstone, Edinburgh.

Murphy-Black T (1989) Postnatal Care At Home - A Descriptive Study of Mothers' Needs and the Maternity Services. A Report to the Scottish Home and Health Department. University of Edinburgh, Nursing Research Unit.

Murphy-Black T (1992) Systems of Midwifery Care in Scotland. Midwifery. 8: pp 113-124.

Murray S (1998) Midwives Make a Difference – Making a Difference Globally. RCM Midwives Journal. June 1998 Vol 1 No 6 pp 188-191.

Myles M (1953) Textbook for Midwives. 1st Edition Churchill Livingstone, England.

Myles M (1968) Textbook for Midwives. 6th Edition Churchill Livingstone, England.

Myles M (1975) Textbook for Midwives. 8th Edition Churchill Livingstone, England.

Myles M (1985) Textbooks for Midwives with Modern Concepts of Obstetric and Neonatal Care. 10th Edition Churchill Livingstone, London.

Myles MB, Huberman AM (1994) Qualitative Data Analysis. Sage Publications, London.

National Health Service Act (Scotland) Act 1947.

National Centre for Health Statistics (US) (1991) National Maternal and Infant Health Follow A longitudinal follow up www.cdc.gov/nchs/

Neil A (1997) Only Cowards Listen To Focus Groups. Daily Mail. Friday 15 August 1997.

Nichols M (1995) Adjustment To New Parenthood: Prenatal Classes Attenders Versus Nonattenders. Birth. 22(1): pp 21-26.

Nolan M (1995) Helping Parents Adapt To Parenthood. British Journal of Midwifery. 3:1 pp 23-26.

Nolan M (1997) Antenatal Education: failing to educate for parenthood. British Journal of Midwifery. 5(1) pp 21-26.

Nolan M (1998) Listening To Women. The Practising Midwife. March 1998, 1(3) pp 4-5.

Nolte AGW (1992) The Standards for Postnatal Care by the Midwife in the Hospital and in the Community. Curationis. Vol 15 No 4 Dec 1992 pp 1-7.

Norr K, Nacion K (1987) Outcomes of Postpartum Early Discharge, 1960-1986: A Comparative Review. Birth. 14: pp 135-141.

Oakley A, Rajan L, Grant A (1990) Social Support and Pregnancy Outcome. British Journal of Obstetrics and Gynaecology. 997, pp 155-162.

Oakley A (1993) Responding to the Health Needs of Women in Pregnancy and the first year of Motherhood. Social Support and Maternity and Child Health Services: a Guide to Good Practice for NHS Purchasers. Public Health Research and Resource Centre, Salford.

O'Meara C (1993) A Diagnostic Model for the Evaluation of Childbirth and Parenting Education Midwifery. 9 pp 28-34.

O'Sullivan S (1998) Woman centred care and midwives' morale. Midwives. Dec 1998 pp 364-5.

Page L (1995) Effective Group Practice In Midwifery. Working With Women. Oxford Blackwell Science Ltd.

Page L (1996) The Backlash Against Evidence-Based Care. Birth. 23;4 December 1996 pp 191-192.

Page L, Phillips J, Drife J (1997) Changing Childbirth: Changing Clinical Decisions. British Journal of Midwifery. Vol 5 (4) pp 203-206.

Patterson PK (1987) A Comparison of Postpartum, Early and Traditional Discharge Groups. Quality Review Bulletin. 1987 13, 11 pp 365- 371.

Penney G, Graham W, Hundley V, Teglingen E , Rennie AM, Fitzmaurice A, Heddle M (1999) Maternity Care Matters - An Audit of Maternity Services In Scotland Scottish Programme for Clinical Effectiveness in Reproductive Health. Dugald Baird Centre for Research in Woman's Health, Aberdeen.

Peterkin G (1995) Fundholding General Practitioners. Paper Presented at the Education Liaison Group (NBS) Conference in Aviemore Nov. 1995.

Phillips JR (1983) Enhancing the Effectiveness of Organisational Change Management. Human Resource Management. 22(1/2): pp 183-199.

Piercy J, Mugford A (1997) Economic Evaluation *in* Campbell R, Garcia J (1997) The Organisation of Maternity Care – A Guide To Evaluation. Chapter 7. Hochland and Hochland Ltd., Cheshire.

Polit DF, Hungler BP (1995) Nursing Research: Principles and Methods. 5th Edition J B Lippincott Company, Philadelphia.

Poole M (1999) The Effect of Selective Visiting on Maternal Anxiety. The British Journal of Midwifery. March 1999 Vol 7, No 3 pp 133-149.

Price A (1995) Sound Choices, Part 1: principles and processes. Modern Midwife. 5(6) June 14-18.

Price A (1995) Sound Choices, Part 2: Modern Midwife. 5(7) July.

Price A (1995) Sound Choices, Part 3: decision making and negligence. Modern Midwife. 5(8) August 10-13.

Pope R, Cooney M, Graham L, (1998) Aspects of Midwifery Care 3: the organisation of midwifery care. British Journal of Midwifery. 6(2); pp 88-92.

Porter M, Mcintyre S (1984) What is, Must Be Best; A Research Note On Conservative or Deferential Responses to Antenatal Care Provision. Social. Science in Medicine 1984 19 pp 1197-1200.

Procter SR, Wright GH (1998) Consumer Responses To Health Care - Women and Maternity Services. International Journal of Quality Assurance.

Procter S (1998) What Determines Quality In Maternity Care? Comparing the Perceptions of Childbearing Women and Midwives. Birth. June 1998 25;2 pp 85-94.

Procter S (1994) A Total Quality Model For Maternity Services British Journal of Midwifery. 2:6 pp 275–278.

Puri B (1996) Statistics in Practice - An illustrated guide to SPSS. Arnold Press, London Ch 7 p75.

Purtell M (1994) Teenage Girls' Attitudes to Breastfeeding. Health Visitor. 67(5); pp 156-157.

Queen Mothers Hospital (1996) Audit of Community Postnatal Care.

Raisler J (1985) Improving pregnancy outcome with nurse-midwifery care. Journal of Nurse Midwifery. 30: pp 189-191.

Rankin J (1999) Primigravid Women and the Effects of Exercise on Psychological Well-being, Pregnancy and Birth Outcome. Unpublished PhD Thesis, University of Glasgow.

RCM Standing Group (1994) Paper 2, Community postnatal Visiting. Midwives. pp 107: 231.

RCOG, DOH (Scotland), 1946 in Garcia J, (1997) Chapter 5 "Finding out What Women and their Families Think of Maternity Services" *in* Campbell R, Garcia J (1997) The Organisation of Maternity Care – A Guide To Evaluation. Hochland and Hochland Ltd., Cheshire.

RCOG, RCM, RCGP (1992) Maternity Care and the New NHS: A joint approach. Report from the presidents of the RCOG & RCM and chairman of RCGP. RCOG, London.

Reid L, Hillan EM, McGuire MM (1998) Woman-centred care: midwives' need to be heard. Practising Midwife. 1(12): pp22-25.

Reid L (1999) The Origins of the Central Midwives Board in Scotland. Unpublished paper submitted to The Wellcome Institute in part fulfilment of research course, University of Glasgow.

Reid M (1997) A Randomised Controlled Trial of Two Interventions To Provide Social Support. British Journal of Midwifery. October 1997, 5(10) pp 610-612.

Reid M, McMillian M (1992 Review of Consumer Studies of Maternity Care - Clinical Resource and Audit Group Working Paper. The Scottish Office, Edinburgh.

Reid M, Garcia J, (1989) Women's Views of Pregnancy and Childbirth *in* Chalmers I, Enkin M, Keirse M (Eds) Effective Care In Pregnancy and Childbirth. Oxford University Press, Oxford.

Reid M, Glazener C, Murray A, Taylor G (2000) Support people or support packs? Women's views about two forms of postnatal support. Paper presented to the 8th International Conference of Maternity Care Researchers, Glasgow, 6-8th September 2000.

Reisken H (1992) Focus Groups: A Useful Technique for Research and Practice in Nursing. Applied Nursing Research. 5:4, pp 197-201.

Renfrew MJ (1994) Midwife vs medical/shared care. *in* Enkin MW, Keirse MJNC, Renfrew MJ, Nielson JP (eds) Pregnancy and childbirth module. Cochrane Database of Systematic Reviews Review No 03295 12 August 1992, Disc Issue No 1.

Renfrew M, Lang S (1994) Early v Late Discharge from Hospital after Childbirth. Cochrane Review, Issue 4 (1999).

Renfrew M, Hannah W, Albers L, Floyd E (1998) Practices that minimise Trauma to the Genital Tract in Childbirth: A systematic Review of the literature. Birth September 1998 25:3 pp 143-160.

Rennie AM, Hundley V, Gurney E, Graham W (1998) Women's Priorities For Care Before and After Delivery. British Journal of Midwifery. Vol 6, No 7. pp 434-438.

Richards J (1997) Too choosy about choice: the responsibility of the midwife. British Journal of Midwifery. 5(3): pp 163-168.

Rider A, (1985) Midwifery After Birth, Nursing Times 7th August 27-28. Midwives Chronicle. 97, 1161, October Supplement.

Righard L, Alade MO (1997) Breastfeeding and The Use of Pacifiers. Birth. 24:2 pp 116-120.

Robinson S (1985) Midwives, Obstetricians and General Practitioners. The Need For Role Clarification Midwifery. 1: pp 103-113.

Robinson J (1998) Suicide: A Major Cause of Maternal Deaths. British Journal of Midwifery. Dec 1998 Vol 6, No 12.

Rogan F, Shmied V, Barclay L, Evetitt L, Wyllie A (1997) 'Becoming A Mother' – Developing A New Theory of Early Motherhood. Journal of Advanced Nursing. 25, pp 877-885.

Ross M. (1999) Promoting the transition to parenthood: The effects of anticipatory guidance on the transition to motherhood among first time parents. Unpublished PhD Thesis, Faculty of Medicine, University of Glasgow.

Rosser J (1998) GP Payments For Maternity Care (Editorial) The Practising Midwife. June 1998 Vol 1 No 6.

Rubin R (1967) Puerperal Change. Nursing Outlook. 9(12): pp753-755.

Rush J, Kitch T (1991) A Randomised Controlled Trial To Measure The Frequency of Use of A Hospital Telephone Line For New Parents. Birth. 18; 4 pp 193-197.

Rush J, Valantis R (1992) Postpartum Care – Home or Hospital? The Canadian Nurse. 88(5): pp29-31.

Rush J, Valentis R (1992) Postpartum Care – Home Or Hospital Canadian Nurse. May pp 29-31.

Sandall J (1995) Choice, Continuity and Control: Changing Midwifery, Towards A Sociological Perspective. Midwifery. 11 pp 201-209.

Sandall J (1997) Midwives, Burnout and Continuity of Care. British Journal of Midwifery. 5(2): pp 106- 111.

Sandall J (1998) Bridging The Gap Between Evidence and Practice. British Journal of Midwifery. October 1998, Vol 6, No 10 pp 624-626.

Schein EH (1986) Organisational Culture and Leadership. Jossey Bass, San Francisco.

Scottish Board of Health (1924) Report of the Departmental Committee on Puerperal Morbidity and Mortality Chairman, Lord Salvesen. HMSO, Edinburgh.

Scottish Office (1998) Acute Services Review Report. The Stationary Office, Edinburgh.

Scottish Office (1998) Towards a New Way of Working - A new way of managing people in the NHS. Scottish Office, Edinburgh.

Scottish Office Home and Health Dept. (1993) Provision of Maternity Services In Scotland: A Policy Review. HMSO, Edinburgh.

Scottish Office Home and Health Dept. (1997) Designed to Care – Renewing the National Health Service in Scotland. MSO, Edinburgh.

Scottish Office, DOH. (1999) MEL(1999)27 Services for women with postnatal depression.

Shields N, Reid M, Cheyne H, Holmes A, Turnbull D, Smith LN (1997) Impact of midwife managed care in the postnatal period: an exploration of the psychosocial outcomes. Journal of Reproductive and Infant Psychology. Vol. 15, pp 91-108.

Shields N, Turnbull D, Reid M, Holmes A, McGinley M, Smith l (1998) Satisfaction with Midwife Managed Care in Different Time Periods: a randomised controlled trial of 1299 women. Midwifery. 14; pp 85-93.

Shields N, Holmes A, Cheyne H, McGinley M, Young D, Gilmour H, Turnbull D, Reid M (1999) Knowing your midwife during labour. British Journal of Midwifery. 7(8) pp 504-510.

Sikorski J, Clement S, Wilson J, (1995) A survey of health professionals views of possible changes in the provision and organisation of antenatal care. Midwifery. 11:61-8.

Sikorski J, Renfrew M (1999) Support for Breastfeeding Mothers. Cochrane Library. Issue 4.

Simkin P (1991) Just Another Day In A Woman's Life ? Part 1 Women's Long Term Perceptions of Their First Birth Experience. Birth. 18: pp 203-210.

Simkin P (1992) Just Another Day In A Woman's Life? Part 11. Nature and Consistency of women's long term memories of their first birth experience. Birth. 19(2) pp 64-81.

Singh D, Newburn M, (2000) Women's Experiences of Postnatal Care. National Childbirth Trust, London.

Sleep J, Grant A (1998) The relief of perineal pain following childbirth: a survey of midwifery practice. Midwifery. 4: pp 118-222.

Small R, Lumley J, Brown S (1992) To Stay Or Not To Stay: Are Fears About Shorter Postnatal Stay In Hospital Justified? Midwifery. 8, pp 170-177.

Small R, Astbury J, Brown S (1994) Depression after childbirth: does social context matter? Medical Journal of Australia. 61; pp 473-477.

Smith L (1996) Beliefs about the midwife's role in home and hospital deliveries. British Journal of Midwifery. 4(5) pp 135-140.

Smith MP (1989) Postnatal concerns of mothers: an update. Midwifery. 5: pp 182-188.

Smith M (1997) The Demise of The Traditional Community Midwife British Journal of Midwifery. May 1997 Vol 5 No 5 pp 252-254.

SPSS for Windows Version 7.1 (computer program) Chicago, Illinois. SPSS inc 1994.

Stamp G, Williams A, Crowther C (1995) Evaluation of Antenatal and Postnatal Support to Overcome Postnatal Depression: A Randomized controlled trial pp 138-143. Birth. 22: 3 September 1995.

Standing Maternity and Midwifery Advisory Committee (1970) Domiciliary Midwifery and Maternity Bed Needs. Chairman, J. Peel, HMSO, London.

Stapelton S (1995) Dangerous Practice Or Good Care? Early Discharge What Are The Real Issues? NCCC News. 1995 10(4-5) :1-3.

Stone D (1993) Design A Questionnaire BMJ. 1993: 307; pp 1264–1266.

Stock J, Wraight A (1993) Developing Continuity of Care in Maternity Services: the implications for midwives. Institute of Manpower Studies, University of Sussex..

Summers A, McKeown Lord J, Walton L (1997) Different women, different views. British Journal of Midwifery. 5(1) pp 46-47.

Summers–Marr S (1996) Women's perceptions and satisfaction of their intrapartum experience within two systems of care. (MSc Dissertation) University of Surrey.

Sweet BR, Tiran D (1997) Mayes Midwifery, a Textbook for Midwives. 12th Edition Bailliere Tindall, London.

Sweet BR (1988) Mayes Midwifery, a Textbook for Midwives. Bailliere Tindall, London.

Symon A (1998) Litigation and Changes in Professional Behaviour. Paper presented at the Iolanthe Conference "Law, Ethics and Professional Accountability" on 19 March 99, in Edinburgh.

Symonds A, Hunt S, (1996) The Midwife and Society MacMillian Press

Takahashi H (1998) Evaluating Routine Postnatal Maternal Temperature Check. British Journal of Midwifery. 6(3) pp 39-143.

Taylor SA, Cronin JJ (1994) Modelling Patient Satisfaction and Service Quality. Journal of Health Care Marketing. 14;1 pp 34-44.

Tew S (1995) Safer Childbirth, A Critical History of Maternity Care. 2nd Edition, Chapman and Hall, London.

Theobald GW (1959) Home on the second day; The Bradford Experiment. The combined maternity scheme. British Medical Journal. 2, pp 1364-1367.

Thomas L; MacMillan E; McColl E; Hale C, Bond S (1995) Comparison of Focus Group and Individual Interview Methodology in Examining Patient

Satisfaction with Nursing Care. Social Science in Health. 1:4 pp 206-220.

Thurston N, Dundas JB (1985) Evaluation of An Early Postpartum Discharge Programme. Canadian Journal of Public Health. 76, pp 384-387.

Tinkler A, Quinney D (1998) Team Midwifery – The Influence of The Midwife Woman Relationship On Women's Experiences and Perceptions of Maternity Care. Journal of Advanced Nursing. 28(1) pp 30-35.

Todd J (1998) Midwives Too Committed To Choice? RCM Midwives Journal. June 1998 Vol 1 No 6 p 183.

Tomes A, Ng, S (1995) Service Quality In Hospital Care: The Development of An In-Patient Questionnaire. International Journal of Health Care Quality Assurance. 8;3 pp 25-33.

Tones K, Tilford S. (1994) Health Education. Effectiveness, efficiency and equity. 2nd Edition. Chapman and Hall, London.

Tucker S, Hall M, Howie P (1996) Should Obstetricians See Women With Normal Pregnancies? A Multicentre Randomised Controlled Trail of Routine Antenatal Care By A General Practitioners and Midwives With Shared Care By Obstetricians British Medical Journal. 312; pp 554-559.

Turnbull D, Reid M, McGinley M, Shields N (1995) Changes In Midwives' Attitudes To Their Professional Role Following The Implementation of The Midwifery Development Unit. Midwifery. 11 pp 110-119.

Turnbull D, McGinley M, Fyvie H, Holmes A, Johnstone I, Cheyne H, Shields N, McLennan B (1995) The Implementation and Evaluation of the Midwifery Development Unit at Glasgow Royal Maternity Hospital. British Journal of Midwifery. 3: pp 465-468.

Twaddle S, Liao X, Fyvie H (1993) An Evaluation of Postnatal Care Individualised To The Needs of The Women. Midwifery. 9;3 pp 154-160.

Twaddle S (1996) Alternative Forms of Care In Obstetrics: An Economic Analysis. PhD Thesis University of Strathclyde, Glasgow.

UKCC (1979, 1986, 1993, 1994) The Midwife's Code of Practice. United Kingdom Central Council For Nursing, Midwifery and Health Visiting, London.

UKCC (1992) Registrar's Letter. Community Postnatal Visiting By Midwives. United Kingdom Central Council For Nursing, Midwifery and Health Visiting, London.

UKCC (1992) The Scope of Professional Practice. UKCC, London.

UKCC (1993) Midwives Rules. UKCC, London.

UKCC (1998) Midwives Rules and Code of Practice. Nurses, Midwives and Health Visitors (Midwives Amendment) Rules 1998. UKCC, London.

Underdown A (1998) Investigating techniques used in parenting classes. Health Visitor. 71:2, pp 65-68.

Waldenstrom U (1987) Early Discharge With Domiciliary Visits and Hospital Care. Scandinavian Journal of Caring Sciences. 1 (2): pp51-58.

Waldenstrom U, Sundelin C, Lindmark G (1987) Early and Late Discharge After Hospital Birth. Health of Mother and Infant In The Postpartum Period. Upsala J Med. Sci 92: pp 301-314.

Waldenstrom U (1989) Early Discharge As Voluntary and Involuntary Alternatives To A Longer Postpartum Stay In Hospital - Effects On Mothers' Experiences and Breast Feeding. Midwifery. 1989 5 pp 189-196.

Waldenstrom U, Neilson C (1993) Women's Satisfaction with Birth Centre Care: A Randomized Controlled Study. Birth. 20(1): pp3-13.

Waldenstrom U, Borg I, Olsson et al (1996) The Childbirth Experience : A Study of 295 New Mothers. Birth. 23: pp 147-153.

Walker P (1995) Should Obstetricians See Women With Normal Pregnancies? Obstetricians Should Be Included In The Integrated Team. BMJ 310; pp 36-38.

Wallach H, Matlin M (1992) College Women's Expectations About Pregnancy, Childbirth and Infant Care: A Prospective Study. Birth. 19;4 pp 202-207.

Walsh D (1997) Hospital Postnatal Care: The End Is Nigh. British Journal of Midwifery. Sept 1997. 5 (9) pp 516-518.

Ward VM, Bertrand JT, Brown LF (1991) The Comparability of Focus Group and Survey Results. Evaluation Review. 15(2) pp 266-283.

Welt S, Cole J, Myers M. (1993) Feasibility of Postpartum Rapid Hospital Discharge: A Study From A Community Hospital Population. American Journal of Perinatology 10: pp 384-387.

White J, Nativio D, Kobert S et al (1992) Content and process in clinical decision making by nurse practitioners. Image: Journal of Nursing Scholarship 24; pp 153-158.

White V (1996) Midwives' perceptions of research based practice. *in* McCormack F, Renfrew M, (eds). The Midwifery Research Database/MIRIAD. 2nd. Edition. Books for Midwives Press, Cheshire.

White E, Brooker C (1997) Survey Methodology and The Issue of Response Rate: The Case Example of A Community Health Nursing Census. NT Research. Vol 2, No 3, pp 164–174.

Williams AS (1997) Women and Childbirth in the Twentieth Century. Sutton Publishing Limited, Stroud.

Williams L, Cooper N (1993) Nurse Managed Postpartum Home Care JOGNN. Jan/Feb 1993 Vol 22 No 1 pp 25-31.

Wood A (1963) The development of the midwifery service in Great Britain. International Journal of Nursing Studies. 1, pp 51-58.

World Health Organisation (1995) The Prevention and management of Puerperal Infections: Report of a Technical Working Group. WHO, Geneva.

World Health Organisation (1998) Postpartum Care of the Mother and Newborn: Report of a Technical Working Group. WHO, Geneva.

Wraight A, Ball J, Seccombe I, Stock J (1993) Mapping Team Midwifery. IMS Report Series 242, Institute of Manpower Studies, Brighton.

Wylie J, Verber I (1994) Why women choose not to breastfeed. Maternal and Child Health. 19(3) pp 76-80.

Yanover M, Jones D, Miller M (1976) Perinatal Discharge of Low Risk Mothers and Infants: Early Discharge With Home Care. New England Journal of Medicine. 294 (13) pp 702-705.

Yocom C (1986) Influence of initial nursing educational preparation on patient assessment. (Doctorial Dissertation, University of Illinois Chicago) Dissertation Abstracts International. 46, 2629 B.

Young D (1996) Editorial Early Discharge - Whose Decision, Whose Responsibility? Birth. 23:2 62-2.

Young D, Lees A, Twaddle S (1997) The Costs To The NHS of Maternity Care: Midwife – Managed vs Shared. British Journal of Midwifery. 5(8) pp 465-471.

Zwergel J, Ende ML, (1989) Maternal Infant Early Discharge Making One Home Visit Count: Journal of Home Health Care Practice. 1:2 pp 16-36.

Appendix I

Antenatal focus letter

Dear

At the Queen Mother's Hospital staff are keen to provide a high quality service and and make the experience of having a baby a joyful and memorable one. At present the Hospital is reviewing the provision of postnatal care to women and their babies. We value women's opinions about the service we provide. So, we are asking you to join a group of between 4 and 8 women to discuss your of expectations and views of the postnatal period and there care and support during that time. If you agree to participate in the group discussion There will be 2 group discussions, the first when you are pregnant to discuss your expectations of the postnatal time and the second about 6 weeks after the baby is born to discuss your perceptions and experiences of the postnatal time.

The discussion will take place before/ following your last antenatal class on @ and it is anticipated that the second discussion will take place immediately following/before the postnatal class reunion Date = @

If you agree to participate in the discussion can you please sign the enclosed consent form and return the form to your parentcraft teacher at the end of this class. I will then write to you confirming details of the group discussion.

You are under no obligation to participate in the discussion but obviously your support and views would be most helpful to us. The group discussion will be tape-recorded so that the midwife can review the content of the discussion. Your name

does no appear on any aspect of the research and all responses are treated in confidence.

All information provided to the research midwife will be treated in strict confidence and will not effect your care in any way.

Once again thank you for your time and support

Yours sincerely

Appendix II

Antenatal focus confirmation letter

Dear

Thank you for agreeing to take part in a group discussion to talk about your expectations of the postnatal period. As I explained when I met you the discussion will take a maximum of a half hour and your contribution will be much appreciated.

This is just a brief note to confirm the date time and venue of the meeting.
The discussion will take place on;

Day and Date

Time

Place

All information provided to the research midwife will be treated in strict confidence and will not effect your care in any way.

Once again thank you for your time and support, I'm looking forward to meeting you again.

Yours sincerely

Margaret M McGuire

Research Midwife

Appendix III

Focus Consent

Queen Mother's Hospital

Yorkhill NHS Trust

Postnatal Care Study

Focus Group Discussion Patient Consent Sheet

I agree to participate in a group discussion to discussion my expectations and perceptions of postnatal care whilst I am pregnant and 6 weeks after the baby is born. I understand that this discussion will be tape recorded.

I understand that the research is confidential and that involvement in this study will not affect my care in any way.

I understand that I can withdraw from the study at any time.

Name (Print name please)

_____

Signed _____ Date _____

Address _____

_____

_____Postcode_____

Telephone number_____

Estimated date of Delivery_____

Witnessed

by_____Designation_____

Date_____

Appendix IV

Focus Information Sheet

THE QUEEN MOTHERS HOSPITAL

Postnatal Care Study Information Sheet

At the Queen Mother's Hospital staff are keen to provide a high quality service and and make the experience of having a baby a joyful and memorable one. At present the Hospital is reviewing the provision of postnatal care to women and their babies. We value women's opinions about the service we provide. So, we are asking you to join a group of between 4 and 8 women to discuss your of expectations and views of the postnatal period and there care and support during that time. If you agree to participate in the group discussion There will be 2 group discussions, the first when you are pregnant to discuss your expectations of the postnatal time and the second about 6 weeks after the baby is born to discuss your perceptions and experiences of the postnatal time.

The discussion will take place before/ following an antenatal class on and it is anticipated that the second discussion will take place immediately following/before the postnatal class reunion.

You are under no obligation to participate in the discussion but obviously your support and views would be most helpful to us. The group discussion will be tape-recorded so that the midwife can review the content of the discussion. Your name does no appear on any aspect of the research and all responses are treated in confidence.

All information provided to the research midwife will be treated in strict confidence and will not effect your care in any way.

Once again thank you for your time and support

Appendix V

Antenatal focus prompt schedule

ANTENATAL FOCUS GROUP PROMPT SCHEDULE.

1. Have you thought about what will happen after the baby is born?
2. What do you know about your postnatal care
3. What do you envisage will be your main needs PN?
4. What are your main concerns about going home from hospital
5. How do you feel about staying in hospital after the baby is born
6. Assuming all is well when do you think is the best time to go home from hospital
7. When would you like to go home from hospital
8. Once home what help if any will you get from family and friends
9. Do you know your community midwife
10. Do you know the what the midwife does once you come home
11. How do you feel about having the midwife visiting you in your own home?
12. Have you any concerns about after you come home from hospital
13. If you had any problems/worries about yourself or the baby who would you ask
14. What are you feelings about coming home with the baby

Appendix VI

Postnatal Focus letter

June 23 1997

Dear

Congratulations on the safe arrival of your baby. I hope that all has gone well since the birth, no doubt you're still finding your feet and wondering what you did with your time before you had a baby!

You were kind enough to participate in a focus group to discuss what you expected after the birth of the baby. It's now time for the second group, at this group we'll discuss what actually happened after the baby was born. I know that this is a very busy time for you but your involvement in this discussion would be really appreciated. As I said at the first group it will hopefully help us pinpoint what the strengths and weaknesses of the service we provide are and in the long run will help other women.

As arranged at the last group the focus group will take place

On

At

Venue Parentcraft Room at the Antenatal clinic, Queen Mothers' Hospital

The discussion will be the same length of time as the last one (approx. 30 mins)

I do you can make this group as your contribution to this research and the group discussion is invaluable.

Please fill in the attached slip and return using the stamped addressed envelope provided.

Looking forward to seeing you again and meeting your baby for the first time.

Yours sincerely

Margaret M McGuire

Appendix VII

Postnatal Focus Prompt Sheet

POSTNATAL FOCUS GROUP PROMPT SCHEDULE.

1. Brief history of labour
2. Were you Debriefed?
3. Support given in hospital
4. Length of stay in hospital
5. Were you well enough prepared for the PN period
6. Well enough prepared for going home
7. How are you feeling now
8. Did what you expected happen
9. Anything midwives can/should do to improve care?
10. Community midwives and PN visits
11. What help did/do you have
12. Would you do things differently next time?
13. Pain control
14. Feeding
15. Baby
16. Worries

Appendix VIII

Midwives Antenatal letter

16th September 1997

Dear

As you know I am studying postnatal care provision and in particular community postnatal care. The first half of the study involved sending questionnaires to 200 low risk postnatal women. Recruitment for this stage has now stopped. In order for research funding to be secured a detailed proposal was submitted to the Chief Scientists' Office. One area that the CSO was particularly interested in was the attitudes and views of midwives about the care and service they provide. I think that is this a very important area as all too often we ask the women and relatives about the care they receive and suggestions for change but little consideration is given to the midwives views.

I am writing to ask you to give your views by completing the enclosed questionnaire. It is quite lengthy but consists mainly of closed response questions, and it should take no more than 15 minutes to complete. This questionnaire asks you what you feel about the care you provide as well as establishing your level of satisfaction with your role. If you want to add anything to an answer, please do. There is also an opportunity in the last page to add any comments. The information you provide will play a major role in this study and the subsequent planning of care for postnatal women. When you fill in this questionnaire consider the care you have provided over the past 6 months and use this as a basis for your responses. A similar questionnaire will be sent to you in March 1998 following evaluation of the new template of postnatal care.

The questionnaire is confidential and given the nature of the questions and the small number of midwives involved it is also anonymous. Usually questionnaires have identification numbers on them so that non-responders can be contacted again. As you can see this questionnaire doesn't, so I will have no way of knowing who has responded.

I would be most grateful if you could complete the questionnaire at your earliest convenience and return it to me in the envelope provided.

Many thanks for your support and help with this.

Kind regards,

Margaret M McGuire

Appendix IX

Midwives Questionnaire 1

Confidential

Postnatal Care Questionnaire (1)

This questionnaire is intended to consider your views about the existing pattern of postnatal care that you provide. Please complete the questionnaire as frankly as possible and feel free to add anything you think relevant.

.

The majority of the questions can be answered by putting a tick in a box ☑ next to the answer you agree with. In some questions you can tick more than one box. A few of the questions ask you to rank the answers in order of importance (1 = most important) Sometimes you may be asked to expand the answer in your own words. The final section gives you an opportunity to make any additional comments.

Thank you for taking the time to read and fill in this questionnaire.

Please answer the following questionnaire by ticking or completing the boxes as required

		for office use
1.	How long have you been practising as a midwife? Number of years ☐☐	☐☐
2.	Year of birth ☐☐☐☐	☐☐
3.	Do you work Full-time ☐ Part-time ☐ Job share ☐	☐
4.	How many hours per week do you work? No of hours ☐☐	
5.	How long have you been a community midwife? ☐☐ years	

6.	How frequently are you required to do 'on call'?	Weekly ☐ Fortnightly ☐ Monthly ☐ Other _____	☐
7.	On average how many 'on-call' hours do you work in a two-week period? Is this	No of hours ☐☐ Too much ☐ About right ☐ Too little ☐	
8.	How many Domino births have you attended in the past year?	Number ☐☐	
9.	How many home births have you attended in the past year?	Number ☐☐	
10.	Would you like to carry a caseload?	Yes ☐ No ☐	☐
11.	Are you in control of the organisation of your working day? If no please explain the factors which influence how your day is organised.	Yes ☐ No ☐	
12.	Do postnatal women get enough support from the community midwife? please explain your answer	Yes ☐ No ☐	

13.	Do you arrange an approximate time with the woman for your next postnatal visit? please explain your answer Are the women satisfied with this arrangement? If No please explain your answer	Yes ☐ No ☐ Yes ☐ No ☐	☐ ☐ ☐ ☐
14.	On average how many postnatal visits do you carry out in a day?	☐☐	☐
15.	On average what proportion of your working day is devoted directly or indirectly to postnatal care	☐☐☐ %	☐
16.	What is the average length of a routine postnatal visit on a low risk primigravidae?	Minutes ☐☐	☐
17.	How would you rate the overall postnatal care given to women in their own homes (circle the appropriate response) Excellent very poor 1 2 3 4 5		☐
18.	Who decides when the midwife visits should stop	Woman ☐ midwife ☐ Both ☐ Other (specify) ☐	☐

19.	On average how long do you continue visiting a low risk postnatal woman for? Days ☐☐ Do you think this is? Too Long ☐ Just right ☐ Too short ☐ Please explain your answer	☐ ☐ ☐
20.	Do you think providing women with a 24-hour telephone number to phone for advice/support reduces the need for postnatal visits? Yes ☐ No ☐	☐

24. At a postnatal visit to a low risk prim, do you?

	First Visit only	Every visit	Half the visits	Never	
examine breasts	☐	☐	☐	☐	☐
examine abdomen/fundus	☐	☐	☐	☐	☐
check perineum/stitches	☐	☐	☐	☐	☐
examine lochia	☐	☐	☐	☐	☐
examine legs	☐	☐	☐	☐	☐
Take maternal temperature	☐	☐	☐	☐	☐
take maternal pulse	☐	☐	☐	☐	☐
Take maternal BP	☐	☐	☐	☐	☐
Carry out parentcraft/health education	☐	☐	☐	☐	☐
Assess psychological condition of mother	☐	☐	☐	☐	☐
Assess domestic situation	☐	☐	☐	☐	☐
take a swab	☐	☐	☐	☐	☐
Provide psychological support	☐	☐	☐	☐	☐
Assess maternal welling	☐	☐	☐	☐	☐
Examine the baby(head to toe)	☐	☐	☐	☐	☐
watch the baby feeding	☐	☐	☐	☐	☐
look at the baby's cord	☐	☐	☐	☐	☐
take the baby's temperature	☐	☐	☐	☐	☐
ask about the baby	☐	☐	☐	☐	☐
Check the baby's bottom	☐	☐	☐	☐	☐
check the baby's skin	☐	☐	☐	☐	☐
take blood from r baby	☐	☐	☐	☐	☐
take a swab from baby	☐	☐	☐	☐	☐
Other (please specify					☐

25.	Generally speaking what is the most time consuming aspect of a postnatal hom visit? (mention more than 1 if appropriate)	☐
26.	What do you consider to be the most important element of the postnatal car you provide to women?	☐
27.	What factors make you more likely to visit the woman more often?	☐
28.	What influences your decision to stop visiting a woman postnatally?	☐
29.	How satisfied are you with your with the care you are providing to postnatal women? Very satisfied very dissatisfied 5 4 3 2 1	☐

30.	How would you rate your level of job satisfaction at present? Very high Very low 5 4 3 2 1 If low, what would improve your job satisfaction?	☐

Please tick the box which best reflects your view of each statement ***(ONE BOX ONLY PER STATEMENT)***

		strongly agree	agree	don't know	disagree	office use
31	I enjoy my job	☐	☐	☐	☐	☐
32	My job is stressful	☐	☐	☐	☐	☐
33	I have plenty opportunities to develop my practice	☐	☐	☐	☐	☐
34	I am happy with my present working pattern and hours	☐	☐	☐	☐	☐
35	I am not able to devote enough time to postnatal women and their babies	☐	☐	☐	☐	☐

36	Breastfeeding mothers usually require more postnatal visits than Bottle feeding mothers	☐	☐	☐	☐	☐
37	I spend too much time on clerical duties	☐	☐	☐	☐	☐
38	The existing organisation of maternity care in my Trust is very effective	☐	☐	☐	☐	☐
39	10 days is too early to discharge postnatal women from the midwives care	☐	☐	☐	☐	☐
40	Women do not get enough support from midwives in the postnatal period	☐	☐	☐	☐	☐
41	Midwives do not place enough emphasis on postnatal visits	☐	☐	☐	☐	☐
42	Some women do not want the midwife to visit them postnatally	☐	☐	☐	☐	☐
42	The postnatal woman should know the midwife who will visit her at home	☐	☐	☐	☐	☐
44	I try to meet those women who I will visit postnatally, antenatally	☐	☐	☐	☐	☐
45	There is a need to alter the organisation of care delivered by community midwives	☐	☐	☐	☐	☐
46	If I had the time I would visit some postnatal women more often	☐	☐	☐	☐	☐
47	I would like to spend more time talking to my postnatal women	☐	☐	☐	☐	☐
48	Low risk postnatal women spend too long in hospital	☐	☐	☐	☐	☐
49	Many women find midwives visits threatening	☐	☐	☐	☐	☐
		strongly agree	agree	don't know	disagree	office use
50	A lot of women are not prepared for coming home from hospital with a baby	☐	☐	☐	☐	☐
51	Continuity of care for women has not improved much over the last 3 years	☐	☐	☐	☐	☐
52	Women are usually discharged from hospital too early after delivery	☐	☐	☐	☐	☐
53	Better collaborative working between midwives, obstetricians and general practitioners would improve the delivery of maternity care	☐	☐	☐	☐	☐

54	General practitioners should be more involved in the delivery of maternity care	☐	☐	☐	☐	☐
55	The midwife is the professional best placed to care for postnatal women and their babies	☐	☐	☐	☐	☐
56	Postnatal care by midwives should continue until the baby is 6 weeks old.	☐	☐	☐	☐	☐
57	Midwives devote too much time to the delivery of community postnatal care	☐	☐	☐	☐	☐
58	Midwives should carry out the 6 week postnatal check on low risk women	☐	☐	☐	☐	☐
59	Midwives don't provide sufficient support to breast feeding mothers	☐	☐	☐	☐	☐

If you have any other comments to make on the subject, I would be very interested to hear your views. Please feel free to use the space below for this.

Thank you very much for taking time to complete this questionnaire.

Mags McGuire

Appendix X

Midwives Questionnaire 2

***Confidential*Postnatal Care Questionnaire (2)**

This questionnaire is intended to consider your views about the existing pattern of postnatal care that you provide. Please complete the questionnaire as frankly as possible and feel free to add anything you think relevant.

The majority of the questions can be answered by putting a tick in a box ☑ next to the answer you agree with. In some questions you can tick more than one box. A few of the questions ask you to rank the answers in order of importance (1 = most important) Sometimes you may be asked to expand the answer in your own words. The final section gives you an opportunity to make any additional comments.

Thank you for taking the time to read and fill in this questionnaire.

Please answer the following questionnaire by ticking or completing the boxes as required

		for office use
1	How long have you been **practising** as a midwife? Number of years ☐☐	☐☐
2	Year of birth ☐☐☐☐	☐☐
3	Do you work Full-time ☐ Part-time ☐ Job share ☐	☐
4	How many hours per week do you work? No of hours ☐☐	
5	How long have you been a community midwife? ☐☐ years	

6	How frequently are you required to do 'on call'?	Weekly ☐ Fortnightly ☐ Monthly ☐ Other _____	☐
7	On average how many 'on-call' hours do you work in a two-week period? Is this	No of hours ☐☐ Too much ☐ About right ☐ Too little ☐	
8	How many Domino births have you attended in the past year?	Number ☐☐	
9	How many home births have you attended in the past year?	Number ☐☐	
10	Would you like to carry a caseload?	Yes ☐ No ☐	☐
11	Are you in control of the organisation of your working day? If no please explain the factors which influence how your day is organised.	Yes ☐ No ☐	
12	Do postnatal women get enough support from the community midwife? please explain your answer	Yes ☐ No ☐	

13	Do you arrange an approximate time with the woman for your next postnatal visit? please explain your answer Are the women satisfied with this arrangement? If No please explain your answer	Yes ☐ No ☐ Yes ☐ No ☐	☐ ☐ ☐ ☐
14	On average how many postnatal visits do you carry out in a day?	☐☐	☐
15	On average what proportion of your working day is devoted directly or indirectly to postnatal care	☐☐☐ %	☐
16	What is the average length of a routine postnatal visit on a low risk primigravidae?	Minutes ☐☐	☐
17	How would you rate the overall postnatal care given to women in their own homes (circle the appropriate response) Excellent very poor 1 2 3 4 5		☐
18	Who decides when the midwife visits should stop	Woman ☐ midwife ☐ Both ☐ Other (specify) ☐	☐

19	On average how long do you continue visiting a low risk postnatal woman for? Days ☐☐ Do you think this is? Too Long ☐ Just right ☐ Too short ☐ Please explain your answer	☐ ☐ ☐
20	Do you think providing women with a 24-hour telephone number to phone for advice/support reduce the need for postnatal visits? Yes ☐ No ☐	☐
21	How has the introduction of the new template of postnatal care effected your role as a community midwife?	☐
22	Has the introduction of the new template of postnatal care effected the duration of postnatal visits? ☐ Visits about the same length ☐ Visits are longer ☐ Visits are shorter Please expand your answer	☐
23	Has the introduction of the new template of postnatal care freed time for other aspects of your job? ☐ Yes ☐ No If **yes** how do you utilise this time? Increase the length of some postnatal visits Carry out more antenatal visits ☐ Carry out administrative duties/paperwork ☐ Update midwifery knowledge ☐ Other (please specify) ☐	
24.		

	At a postnatal visit to a low risk prim, do you?					
		First Visit only	**Every visit**	**Half the visits**	**Never**	
	examine breasts	☐	☐	☐	☐	☐
	examine abdomen/fundus	☐	☐	☐	☐	☐
	check perineum/stitches	☐	☐	☐	☐	☐
	examine lochia	☐	☐	☐	☐	☐
	examine legs	☐	☐	☐	☐	☐
	Take maternal temperature	☐	☐	☐	☐	☐
	take maternal pulse	☐	☐	☐	☐	☐
	Take maternal BP	☐	☐	☐	☐	☐
	Carry out parentcraft/health education	☐	☐	☐	☐	☐
	Assess psychological condition of mother	☐	☐	☐	☐	☐
	Assess domestic situation	☐	☐	☐	☐	☐
	take a swab	☐	☐	☐	☐	☐
	Provide psychological support	☐	☐	☐	☐	☐
	Assess maternal welling	☐	☐	☐	☐	☐
	Examine the baby(head to toe)	☐	☐	☐	☐	☐
	watch the baby feeding	☐	☐	☐	☐	☐
	look at the baby's cord	☐	☐	☐	☐	☐
	take the baby's temperature	☐	☐	☐	☐	☐
	ask about the baby	☐	☐	☐	☐	☐
	Check the baby's bottom	☐	☐	☐	☐	☐
	check the baby's skin	☐	☐	☐	☐	☐
	take blood from r baby	☐	☐	☐	☐	☐
	take a swab from baby	☐	☐	☐	☐	☐
	Other (please specify					☐
25.	Generally speaking what is the most time consuming aspect of a postnatal hom visit? (mention more than 1 if appropriate)					☐

26.	What do you consider to be the most important element of the postnatal care you provide to women?	☐
27.	What factors make you more likely to visit the woman more often?	☐
28.	What influences your decision to stop visiting a woman postnatally?	☐
29.	How satisfied are you with your with the care you are providing tc postnatal women? Very satisfied very dissatisfied 5 4 3 2 1	☐

30.	How would you rate your level of job satisfaction at present? Very high Very low 5 4 3 2 1 If low, what would improve your job satisfaction?	☐

Please tick the box which best reflects your view of each statement *(ONE BOX ONLY PER STATEMENT)*

		strongly agree	agree	don't know	disagree	strongly disagree	office
31	I enjoy my job	☐	☐	☐	☐	☐	☐
32	My job is stressful	☐	☐	☐	☐	☐	☐
33	I have plenty opportunities to develop my practice	☐	☐	☐	☐	☐	☐
34	I am happy with my present working pattern and hours	☐	☐	☐	☐	☐	☐
35	I am not able to devote enough time to postnatal women and their babies	☐	☐	☐	☐	☐	☐
36	Breastfeeding mothers usually require more postnatal visits than Bottle feeding mothers	☐	☐	☐	☐	☐	☐

37	I spend too much time on clerical duties	☐	☐	☐	☐	☐	☐
38	The existing organisation of maternity care in my Trust is very effective	☐	☐	☐	☐	☐	☐
39	10 days is too early to discharge postnatal women from the midwives care	☐	☐	☐	☐	☐	☐
40	Women do not get enough support from midwives in the postnatal period	☐	☐	☐	☐	☐	☐
41	Midwives do not place enough emphasis on postnatal visits	☐	☐	☐	☐	☐	☐
42	Some women do not want the midwife to visit them postnatally	☐	☐	☐	☐	☐	☐
42	The postnatal woman should know the midwife who will visit her at home	☐	☐	☐	☐	☐	☐
44	I try to meet those women who I will visit postnatally, antenatally	☐	☐	☐	☐	☐	☐
45	There is a need to alter the organisation of care delivered by community midwives	☐	☐	☐	☐	☐	☐
46	If I had the time I would visit some postnatal women more often	☐	☐	☐	☐	☐	☐
47	I would like to spend more time talking to my postnatal women	☐	☐	☐	☐	☐	☐
48	Low risk postnatal women spend too long in hospital	☐	☐	☐	☐	☐	☐
49	Many women find midwives visits threatening	☐	☐	☐	☐	☐	☐
50	A lot of women are not prepared for coming home from hospital with a baby	☐	☐	☐	☐	☐	☐
51	Continuity of care for women has not improved much over the last 3 years	☐	☐	☐	☐	☐	☐
52	Women are usually discharged from hospital too early after delivery	☐	☐	☐	☐	☐	☐
53	Better collaborative working between midwives, obstetricians and general practitioners would improve the delivery of maternity care	☐	☐	☐	☐	☐	☐
54	General practitioners should be more involved in the delivery of maternity care	☐	☐	☐	☐	☐	☐
55	The midwife is the professional best placed to care for postnatal women and their babies	☐	☐	☐	☐	☐	☐

56	Postnatal care by midwives should continue until the baby is 6 weeks old.	☐	☐	☐	☐	☐	☐
57	Midwives devote too much time to the delivery of community postnatal care	☐	☐	☐	☐	☐	☐
58	Midwives should carry out the 6 week postnatal check on low risk women	☐	☐	☐	☐	☐	☐
59	Midwives don't provide sufficient support to breast feeding mothers	☐	☐	☐	☐	☐	☐

If you have any other comments to make on the subject, I would be very interested to hear your views. Please feel free to use the space below for this.

Thank you very much for taking time to complete this questionnaire.

Margaret McGuire

Appendix XI

Patient Information sheet – PN Study

Queen Mother's Hospital
Postnatal Care Study

Patient Information Sheet

At the Queen Mother's Hospital staff are keen to provide a high quality service and make the experience of having a baby a joyful and memorable one. At present the Hospital is reviewing the provision of postnatal care to women and their babies. We value women's opinions about the service we provide. So over the next few months you may be asked to complete a questionnaire or meet with the midwife to discuss your expectations/views of the postnatal care we provide.

If you are one of these women you will receive a confidential questionnaire and an addressed pre paid envelope about 3 weeks after the baby is born. The research midwife will also review your maternity records to collect information about your pregnancy and labour. You are under no obligation to complete the questionnaire but obviously your support and comments would be most helpful to us. Your name does not appear on the questionnaire and all responses are treated in confidence. The only person who will be aware of the individuals involved in the study will be the research midwife.

If you say on the questionnaire that you would be happy to talk to the research midwife she may contact you to see if you are still willing to meet and then arrange a meeting at a mutually convenient time.

All information provided to the research midwife will be strictly confidential and will not affect your care in any way.

If for any reason you do not want to be included in this study then please tell a midwife .

Appendix XII

Postnatal Consent Sheet

Queen Mother's Hospital

Yorkhill NHS Trust

Postnatal Care Study

Patient Consent Sheet

I have read the patient information sheet and a midwife has explained the research project to me.

I understand that the research midwife will review my notes and I will receive a postal questionnaire when my baby is about 3 weeks old. If I agree the midwife may ask to discuss postnatal matters in more depth.

I understand that the research is confidential and the only person who will be aware of the individuals in the study is the research midwife. Involvement in this study will not affect my care in any way.

I understand that I can withdraw from the study at any time.

Signed _____ Date _____

Address _____

_____

_____Postcode_____

Witnessed

by_____Designation_____

Date_____

Appendix XIII

Letter accompanying PN Questionnaire

Date

Dear

Thank you for agreeing to fill in this questionnaire about your postnatal care. We hope that you're enjoying having a baby in the family and that both yourself and the baby are well.

As we explained to you in the postnatal ward the Queen Mother's Hospital is reviewing the provision of postnatal care to women and their babies. The best way of doing this is getting the opinions of the women we look after.

Enclosed you will find a questionnaire and a stamped addressed envelope, we would be most grateful if you could fill in and post the questionnaire at your earliest convenience.

Although the questionnaire *is lengthy it will not take long to fill in as in most cases* you just need to tick the appropriate box. You are under no obligation to complete the questionnaire but obviously your support and comments would be most helpful to us.

Your name does not appear on the questionnaire and all responses are treated in confidence. The only person who will be aware of the individuals involved in the study is the research midwife. If you say on the questionnaire that you would be happy to talk to the research midwife she may contact you to see if you are still willing to meet and then arrange a mutually convenient time.

All information provided to the research midwife will be strictly confidential and will not affect your care in any way.

Once again many thanks for providing us with your opinions and information about your experiences of postnatal care. This information will help us to provide a postnatal care service, which is geared to the needs of women.

Yours sincerely

Yvonne Bronsky

Margaret McGuire

Yvonne Bronsky
Clinical Midwifery Specialist (Community)
The Queen Mother's Hospital

Margaret McGuire
Midwife Researcher
The Queen Mother's Hospital

Appendix XIV

Follow up postnatal letter

Date

Dear

Thank you for agreeing to fill in this questionnaire about your postnatal care. We hope that you're enjoying having a baby in the family and that both yourself and the baby are well.

As we explained to you in the postnatal ward the Queen Mother's Hospital is reviewing the provision of postnatal care to women and their babies. The best way of doing this is getting the opinions of the women we look after.

Enclosed you will find a questionnaire and a stamped addressed envelope, we would be most grateful if you could fill in and post the questionnaire at your earliest convenience.

We did send you a questionnaire a couple of weeks ago, but it could be that it got lost in the post or mislaid. We would really appreciate it if you could fill in the questionnaire. If for some reason you do not wish to complete the questionnaire, then put it in the envelope provided and return it to us. This will ensure that you don't get any further reminder letters.

Your name does not appear on the questionnaire and all responses are treated in confidence. All information provided to the research midwife will be strictly confidential and will not affect your care in any way.

Once again many thanks for providing us with your opinions and information about your experiences of postnatal care. This information will help us to provide a postnatal care service, which is geared to the needs of women.

If you have returned the questionnaire in the past couple of days then please disregard this letter.

Yours sincerely

Yvonne Bronsky

Margaret McGuire

Yvonne Bronsky
Clinical Midwifery Specialist (Community)
The Queen Mother's Hospital

Margaret McGuire
Midwife Researcher
The Queen Mother's Hospital

Appendix XV

Postnatal questionnaire

Confidential Postnatal Care Questionnaire

Congratulations on the birth of your baby. When you came home from hospital the midwife and possibly other health care professionals visited you in your own home. This questionnaire is about the care and support you received at home following the birth of your baby. Please complete the questionnaire as frankly as possible and feel free to add anything you think relevant.

The majority of the questions can be answered by putting a tick in a box ☑ next to the answer you agree with. In some questions you can tick more than one box. A few of the questions ask you to rank the answers in order of importance (1 = most important) Sometimes you may be asked to expand the answer in your own words. The final section gives you an opportunity to make any additional comments.

Thank you for taking the time to read and fill in this questionnaire.

Section 1 About you

1. Is this your first baby?

Yes ☐

No ☐

If not how many other children do you have ? ☐

2. Do you?

Live alone ☐

Live with partner ☐

Live with husband ☐

Other (please specify)

3. How old is your baby now ? (in days) ☐☐

4. Who decided when you and your baby were
. . . . . midwife ☐
doctor ☐
myself ☐
midwife and myself ☐
other ☐

If **other** please explain :

5. Were you satisfied with the length of time you spent in hospital? Yes ☐
No ☐

Please expand

6. How satisfied were you with your stay in hospital? Satisfied ☐
Satisfied in some ways but not in others ☐
Dissatisfied ☐

7. Had you met the community midwife before she visited you at home after your baby was born ?

Yes ☐

No ☐

Don't know ☐

If **yes** : was this at

a hospital clinic ☐

at your GP's surgery ☐

in your home ☐

in the postnatal ward ☐

other ☐

if **other** please specify :

8. Did your community midwife explain her role in caring for you and your baby ?

yes ☐

no ☐

9.	Have you experienced any of the following problems since you came home from hospital? - if **yes :** please tick the box(es)	**Yes**
	engorged breasts	☐
	painful perineum / stitches	☐
	urinary / bladder problems	☐
	backache	☐
	heavy vaginal discharge	☐
	extreme tiredness	☐
	cracked nipples	☐
	other : please specify	☐

If you experienced any problems, what advice and support were you given and from whom ?

Section 2 Your baby

10.

What is your baby's name?

11. Since you came home from hospital has your baby experienced any of the following problems: (please tick the appropriate box(es)

feeding problems	☐
infection	☐
sticky eyes	☐
jaundice	☐
other (please specify)	☐

If your baby did have problems, what advice and support were you given and from whom ?

12 Is your baby more demanding than you anticipated

Yes	☐
No	☐
Sometimes	☐

Section 3 Feeding your baby

13. While in hospital what method of feeding did you use after your baby was born ?

- breast ☐
- bottle ☐
- breast and bottle ☐

Why did you choose this method ?

14. When you came home from hospital which method of feeding your baby did you use?

- breast ☐
- bottle ☐
- breast and bottle ☐

15. How are you feeding your baby now?

- breast ☐
- bottle ☐
- breast and bottle ☐

16. Was the help/support you received for feeding the baby ?

- inadequate ☐
- adequate ☐
- didn't need any ☐

17. Have you changed your method of feeding since your baby was born ?

- yes ☐
- no ☐

If **yes :** please explain when and why you changed

Section 4 Home from Hospital

18. After coming home from hospital, how many times did your community midwife visit ? ☐☐

Looking back, do you think the number of visits was

too few ☐

just right ☐

too many ☐

19. Did the same midwife visit you each time ? yes ☐

no ☐

If **no :** how many midwives visited you altogether ? ☐☐

Did this have any effect on your care?

20. Did you feel able to ask the midwife any questions that concerned you ? yes ☐

no ☐

If **yes :** how helpful were the answers ? very helpful ☐

not very helpful ☐

no help at all ☐

myself ☐

21. Who decided when the next visit was due ?

the midwife and myself ☐

the midwife ☐

GP ☐

22. What was the average length of each visit ? ☐☐

(in minutes)

Was this

too long ☐

just right ☐

too short ☐

23. Did you know the day the midwife was due to visit you ?

yes ☐

no ☐

24. Did you know the approximate time the midwife was due to visit you ?

no ☐

yes ☐

no ☐

25. Were you satisfied with this arrangement ?

yes ☐

no ☐

26. Is there anything else the midwife could have done to help you after you came home ?

yes ☐

no ☐

If **yes**, please say what

27. Please give an overall rating of the postnatal care you received after coming **home** from hospital **(circle the appropriate number)**

excellent 1 2 3 4 5 very poor

28. How many days old was your baby when the midwife stopped visiting you ? ☐☐

was this ?

- too soon ☐
- about right ☐
- too long ☐

29. Who decided when the midwife should stop visiting you ?

- myself ☐
- myself and the midwife ☐
- the midwife ☐

30. During the time the midwife was visiting you, did you receive any visits from

- your GP ☐
- the Health Visitor ☐
- other (specify) ☐

Please explain who came to see you and why

31. Since the midwife stopped visiting you have you received any visits from

your GP ☐

your Health ☐

Visitor ☐

Other (specify)

Please explain who came to see you and why

32. At each visit did the midwife :

	every visit	**half the visits**	**once**	**never**
examine your breasts	☐	☐	☐	☐
examine your tummy	☐	☐	☐	☐
check your stitches	☐	☐	☐	☐
examine your sanitary pad	☐	☐	☐	☐
examine your legs	☐	☐	☐	☐
take your pulse	☐	☐	☐	☐
take a swab from you	☐	☐	☐	☐
talk with you	☐	☐	☐	☐
ask you about yourself	☐	☐	☐	☐
examine your baby	☐	☐	☐	☐
watch you feeding your baby	☐	☐	☐	☐
look at your baby's cord	☐	☐	☐	☐
take your baby's temperature	☐	☐	☐	☐
ask you about the baby	☐	☐	☐	☐
check your baby's bottom	☐	☐	☐	☐
check your baby's skin	☐	☐	☐	☐
take blood from your baby	☐	☐	☐	☐
take a swab from your baby	☐	☐	☐	☐

33. Were you given a phone number to contact the community midwife if you needed her?

yes ☐

no ☐

don't remember ☐

34. Did you use this phone number to contact the midwife?

yes ☐

no ☐

If **yes** please explain why you contacted her and the outcome of the phone call

35. How helpful did you find having a phone number to contact the midwife

a lifeline ☐

very helpful ☐

handy to have ☐

not much use ☐

a waste of time ☐

The following are statements about your postnatal care at home, please tick the box which best reflects your view (*please tick only one box for each statement*)

SECTION 5 *Your Views*

	strongly agree	agree	Uncertain	dis-agree	strongly dis-agree
36. I was happy to have the midwife visiting me in my own home	☐	☐	☐	☐	☐
37. I would have preferred to visit the midwife at the Health Centre/GP surgery	☐	☐	☐	☐	☐
38. I found the midwife's visits pointless	☐	☐	☐	☐	☐
39. Having a midwife visit me was a real lifeline	☐	☐	☐	☐	☐
40. I received conflicting advice from the midwives.	☐	☐	☐	☐	☐
41. The midwife helped me feel more in control	☐	☐	☐	☐	☐
42. The midwife was more interested in my baby than me.	☐	☐	☐	☐	☐
43. The midwife visits were too short	☐	☐	☐	☐	☐
44. I am very happy with the type of postnatal care I received.	☐	☐	☐	☐	☐
45. The midwife took time to talk to me	☐	☐	☐	☐	☐

46.	I was happy to allow the midwife to make all the decisions regarding the care of myself and the baby.	☐	☐	☐	☐	☐
47.	It is important to have the same midwife visiting me at home.	☐	☐	☐	☐	☐
48.	I looked forward to the midwife visiting me in my own home.	☐	☐	☐	☐	☐
49.	The midwife was interested in how I was feeling	☐	☐	☐	☐	☐
50	Every woman should meet their community midwife before the baby is born.	☐	☐	☐	☐	☐
51	I would have liked more midwife visits	☐	☐	☐	☐	☐
52	I had confidence in my community midwife	☐	☐	☐	☐	☐
53	I was not prepared for coming home from hospital with a baby	☐	☐	☐	☐	☐
54	The midwife helped the transition from hospital to home	☐	☐	☐	☐	☐
55	The midwife didn't give me the support I needed	☐	☐	☐	☐	☐
556	Midwives do not provide enough care to new mothers at home	☐	☐	☐	☐	☐
57	I thought the midwife would have been more of a help to me	☐	☐	☐	☐	☐

58	The midwife stopped visiting me too soon	☐	☐	☐	☐	☐
59	I felt relaxed when the midwife visited	☐	☐	☐	☐	☐
60	I found the midwives visits threatening	☐	☐	☐	☐	☐
61	Next time I would like to go home from hospital sooner	☐	☐	☐	☐	☐

62 Comparing your present state of health with how you felt before your pregnancy, how do you feel at present?

Better ☐

About the same ☐

Worse ☐

Much worse ☐

Please expand your answer

63. Who helps you care for your baby now ?

_____

64. Do you get enough help to look after your baby?

65. Is there anything else that could have improved your care since you came home ?

Additional comments

If you have any additional comments to add to this questionnaire about any aspect of the care you received, please put them down here or overleaf.

If you would be willing to meet with the research midwife to discuss your experiences and views of postnatal care, please print your name in block capitals along with a contact number to reach you. thank you

Name :	
Address : **Post Code :**	
Telephone :	

Thank you for completing this questionnaire your time and support are greatly appreciated